

09750

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>Lifetime</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>600 National Highway-La Vale</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Lula</b> Middle <b>L.</b> Last <b>Boden</b>				4. DATE OF DEATH Month <b>9</b> Day <b>2</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Oct. 8, 1898</b>	
9. AGE (In years last birthday) yrs. <b>60</b>		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Franklin W. Hammersmith</b>				14. MOTHER'S MAIDEN NAME <b>Mary Frances Robinson</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>Jack D. Boden, Cumberland, Md.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Urterial obstruction</b> DUE TO (c) <b>Carcinoma of cervix with metastases</b> INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>2 1/2 yrs</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>Sept 1, 1959</b> to <b>Sept 2, 1959</b> , that I last saw the deceased alive on <b>Sept 1, 1959</b> and that death occurred at <b>4 P. M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland at Washington St.</b> DATE SIGNED <b>Sept. 3, 1959</b>							
ACTUAL SIGNATURE <b>Thomas F. Lewis</b> M.D.							
PHYSICIAN'S NAME (Type) <b>Thomas F. Lewis, MD</b>				<b>Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9-5-59</b>			
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>				22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 8 '59</b>			
				24b. REGISTRAR'S SIGNATURE <b>Orlino L. Thomas</b>			

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TO HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09751

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09724

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Mineral</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ridgeley,</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hosp. D.O.A.</b>				d. STREET ADDRESS <b>4 Carpenter Ave.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Retta</b> Middle <b>May</b> Last <b>Brant</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>24,</b> Year <b>19 59</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 24, 1871</b>		9. AGE (In years last birthday) <b>88</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife,</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Sharpsburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Jonathan Moats</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Stobbs</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Arthur E. Brant</b> Address <b>Ridgeley, W. Va.</b> <b>4 Carpenter Ave.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary occlusion</b> DUE TO <b>420-1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>coronary sclerosis</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <b>Benedict Skitarelic</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <b>Dr. Benedict Skitarelic</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept. 24, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/26/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b> ADDRESS <b>Cumberland, Md.</b>				24a. REC'D BY REGISTRAR <b>SEP 28 59</b> DATE		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please excuse the certificate by writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09803

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Westernport-Rural</b>		c. LENGTH OF STAY IN 1b <b>23 hrs 2 Ds.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1 mile East of Westernport</b>		d. STREET ADDRESS <b>Green St.</b>	
3. NAME OF DECEASED (Type or print) <b>McComas</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 13, 1893</b>
9. AGE (In years last birthday) <b>66</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Kennerd Broadwater</b>	
14. MOTHER'S MAIDEN NAME <b>Annie Wiland</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. Joseph Grandstaff-Suitland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Strangulation by Rope</b> <b>974x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>around neck</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>—</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Hanged self by neck by rope</b>	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State) <b>Moscow Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W O McLane</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>W O McLane</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/21/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill</b>		22d. LOCATION (City, town, or county) (State) <b>Moscow Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W O McLane</b>		ADDRESS <b>Westernport, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur G. Kneiss</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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1997



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**09752**  
**CERTIFICATE OF DEATH**

**09726**

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Mineral</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>Mins.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>D.O.A. Memorial Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Violet</b> Middle <b>Pearl</b> Last <b>Browning</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>24</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 27, 1918</b>	9. AGE (In years last birthday) <b>41</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James T. Shrout</b>				14. MOTHER'S MAIDEN NAME <b>Mary F. Stonebraker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-07-6410</b>		17. INFORMANT Address <b>Mr. Irvin Browning, Wiley Ford, W. Va.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute congestive heart failure</b> <b>410X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Mitral stenosis</b> DUE TO (c) <b>Rheumatic fever</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 hours.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept. 22, 1959</b> to <b>Sept. 24, 1959</b> , that I last saw the deceased alive on <b>Sept. 24, 1959</b> , and that death occurred at <b>11:05 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED _____ ACTUAL SIGNATURE <i>[Signature]</i> M.D. <b>133 Virginia Avenue 9-25-59</b> PHYSICIAN'S NAME (Type) <b>G. Overton Himmelwright, M.D. Cumberland, Maryland</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-27-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 29 '59</b>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove the other papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





09753

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>58yrs</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>216 Arch Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Jasper</b> Middle <b>Carl</b> Last <b>Bucy</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>29</b> Year <b>1959</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 18, 1885</b>
9. AGE (In years last birthday) <b>73</b> yrs.		IF UNDER 1 YEAR Months <b>7</b> Days <b>18</b> Hours <b>19</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Bottle Washer Milk Plant</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Towncreek, Maryland</b>	
11. BIRTHPLACE (State or foreign country) <b>USA</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Denton B. Bucy</b>		14. MOTHER'S MAIDEN NAME <b>Mary Huff</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214-05-8083 A</b>	
17. INFORMANT <b>Nellie Mae Redhead</b>		Address <b>same as above</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor Pulmonale</b> DUE TO <b>Chronic Asthmatic Bronchitis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>501 X</b> (c) <b>5 yrs</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>5 yrs</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>19</b> p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/24/57</b> , 19____, to <b>9/29/59</b> , 19____, that I last saw the deceased alive on <b>9/28/59</b> , 19____, and that death occurred at <b>8:30 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>Cumberland, Md.</b> DATE SIGNED <b>9/30/59</b>			
ACTUAL SIGNATURE <b>Richard J. Williams</b>		PHYSICIAN'S NAME (Type) <b>Richard J. Williams 122 N. Centre St. Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>10-2-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		24a. REC'D BY REGISTRAR <b>OCT 5 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Carlton S. Kraw</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove certain papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09728

09754

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b> c. LENGTH OF STAY IN 1b <b>3 DAYS</b> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>X LONA CONING</b> d. STREET ADDRESS <b>Detmold</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>CAMERON</b> Last <b>CAMERON</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>OCTOBER 12, 1886</b> 9. AGE (In years last birthday) <b>72 yrs.</b> 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House Work Own Home</b> 11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b> 12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
13. FATHER'S NAME <b>ROBERT MOFFATT</b>		14. MOTHER'S MAIDEN NAME <b>MARTHA STARBRIGHT</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NONE</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>422.1</b> DUE TO <b>Arteriosclerotic Cardia</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Vascular disease</b> DUE TO <b>Prolonged active heart failure (St.)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>UNKNOWN</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>8-31-1959</b> to <b>9-3-1959</b> that I last saw the deceased alive on <b>9-3-1959</b> , and that death occurred at <b>7:43 AM</b> from the causes and on the date stated above. ACTUAL SIGNATURE <b>W.F. Williams</b> ADDRESS (Street, city or town, state) <b>Cumberland, Md</b> DATE SIGNED <b>9-3-59</b> PHYSICIAN'S NAME (Type) <b>W.F. WILLIAMS</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/6/1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 8 '59</b>	
ADDRESS <b>LONA CONING, MD.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kneass</b>	

DATE OF BIRTH

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ALLIANCE

ALLIANCE

ORGANIZATION

1 DAY

TO ACCORDING TO

MEMORIAL HOSPITAL

MEMORIAL

STATE OF NEW YORK

STATE OF NEW YORK

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
ISM 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
09755  
CERTIFICATE OF DEATH

09729

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>11 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>B.</b> Middle <b>HARRISON</b> Last <b>CARL</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>25</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-22-1889</b>
9. AGE (In years last birthday) <b>69</b> yrs.		10. IF UNDER 1 YEAR Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min. <b>69</b>	11. IF UNDER 24 HRS. Months <b>69</b> Days <b>69</b> Hours <b>69</b> Min. <b>69</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad clerk</b>	
11. BIRTHPLACE (State or foreign country) <b>HANCOCK, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DANIEL CARL</b>		14. MOTHER'S MAIDEN NAME <b>ANNIE SPRENKLE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> (If yes, give war or dates of service) <b>W W I</b>		16. SOCIAL SECURITY NO. <b>705-10-4581</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>610x</b> DUE TO <b>Benign hyperbrosy postate</b> Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <b>antennosclerosis, coronary sclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c) <b>antennosclerosis, coronary sclerosis</b>		18. INTERVAL BETWEEN ONSET AND DEATH <b>?</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>	
20c. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>		20d. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20e. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>9-14-59</b> to <b>9-25-59</b> that I last saw the deceased alive on <b>9-24-59</b> and that death occurred at <b>4:30 A.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Howard L. Tolson</b>		ADDRESS (Street, city or town, state) <b>Cumberland Md.</b>	
PHYSICIAN'S NAME (Type) <b>DR. HOWARD L. TOLSON</b>		DATE SIGNED <b>9-25-59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/27/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>RoseHill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		ADDRESS <b>Cumberland Maryland</b>	
24a. REC'D BY REGISTRAR <b>SEP 29 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Thomas</b>	

08130

CENTRICATE OF DEATH

08130

5. *Handwritten signature*

*Handwritten signature*

*Handwritten signature*

DR. HENRY L. TOLSON

1953

and L. Shilox



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09756

CERTIFICATE OF DEATH

09730

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>02</u> <u>Cumberland,</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>202 Columbia St. City.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First <u>Norman</u> Middle <u>E</u> Last <u>Chirdon</u>		4. DATE OF DEATH Month <u>September</u> Day <u>7</u> Year <u>1959</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/12,-1915</u>	9. AGE (In years last birthday) <u>44</u> yrs.	IF UNDER 1 YEAR Months <u>14</u> Days <u>14</u> Hours <u>14</u> Min.	IF UNDER 24 HRS. Hours <u>14</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Salesman</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Pa.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Charles Chirdon</u>				14. MOTHER'S MAIDEN NAME <u>Gertrude Conrad</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>70</u>		INFORMANT <u>Wife Jane</u>		Address <u>202 Columbia St.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary Artery Disease</u> DUE TO (c) <u>2-3 years</u>						INTERVAL BETWEEN ONSET AND DEATH <u>1 hour</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> of work <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>January</u> , 19 <u>58</u> , to <u>September</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>Sept. 7</u> , 19 <u>59</u> , and that death occurred at <u>4:15 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>441 N. Centre St</u> DATE SIGNED <u>9.9.59</u>							
ACTUAL SIGNATURE <u>William P. James</u>		M.D. <u>441 N. Centre St</u> <u>9.9.59</u>					
PHYSICIAN'S NAME (Type) <u>Dr. William P. James</u>		<u>Cumberland, Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/10/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>S.S. Peter + Paul</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Steiner</u>		ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 11 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. James</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09751

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09731

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> <u>MARYLAND</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>CUMBERLAND</u> c. LENGTH OF STAY IN 1b <u>8 DAYS</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>SACRED HEART HSOPITAL.</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>WEST VIRGINIA</u> b. COUNTY <u>✓</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>PAW PAW</u> <u>85 x - 3</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <u>Patricia</u> <u>Clark</u>				4. DATE OF DEATH Month Day Year <u>Sept.</u> <u>30</u> <u>19 59</u>			
5. SEX <u>FEMALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>MARCH 21, 1939</u>	
9. AGE (In years last birthday) <u>20</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>WEST VIRGINIA</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>HOMER PARKER</u>				14. MOTHER'S MAIDEN NAME <u>MARY BOWERS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT <u>PATIENT'S CHART</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pulmonary Embolism, Massive</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>465 X</u> (c), stating the underlying cause last. DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							INTERVAL BETWEEN ONSET AND DEATH <u>10 Minutes</u>
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Benedict Skitarelic</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>Benedict Skitarelic, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Sept. 30, 1959</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>OCT. 3, 1959</u>		<u>WOODROW CEM.</u>		<u>PAW PAW, W. VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Parker Funeral Home, Berkeley Springs</u>				24a. REC'D BY REGISTRAR <u>DATE OCT 5 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Knorr</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PW3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09758

## CERTIFICATE OF DEATH

09732

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Alle gany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>11 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Theresa</b> Middle <b>Elizabeth</b> Last <b>Cline</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>22</b> Year <b>19 59</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>4/1/98</b>	
9. AGE (In years lost birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Lloyd Ryland (Dec)</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Brodigan (Dec)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO. <b>None</b>			
INFORMANT <b>Mrs. Kenneth Imler Altoona, Penna.</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary atelectasis bilateral</b> DUE TO <b>420.1</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Myocardial ischemia</b> DUE TO <b>Coronary artery insufficiency</b> (c) <b>Quodernal obstruction due to chronic cholecystitis (pericholecystitis)</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Quodernal obstruction due to chronic cholecystitis (pericholecystitis)</b>							
INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs</b>							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>Sept 17</b> , 19 <b>59</b> , to <b>Sept 21</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Sept 20</b> , 19 <b>59</b> , and that death occurred at <b>8 A</b> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Thomas F. Lewis</b>				ADDRESS (Street, city or town, state) <b>Hotel Algonquin Cumberland Maryland</b>			
PHYSICIAN'S NAME (Type) <b>TITOMAS F. LEWIS M.D.</b>				DATE <b>Sept 24 '59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9/25/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Patrick's Cem.</b>	
22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 28 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur L. Thomas</b>							

04732

CERTIFICATE OF DEATH

04732

04732

MADE IN U.S.A.

Form with multiple lines for text entry, including fields for name, date, and location. The text is mostly illegible due to fading and bleed-through.



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09733

Reg. Dist. No.

09755

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Allegany</b> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>													
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>			c. LENGTH OF STAY IN 1b  			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland,</b>											
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>119 So. Allegany St.,</b>				d. STREET ADDRESS <b>119 So. Allegany St.,</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
<b>3. NAME OF DECEASED</b> (Type or print) First <b>CHARLES</b> Middle <b>LEO</b> Last <b>COLLINS</b>				<b>4. DATE OF DEATH</b> Month <b>Sept.</b> Day <b>19,</b> Year <b>19 59</b>													
<b>5. SEX</b> <b>Male</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> <b>WIDOWED</b> <input type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <b>June 13, 1904</b>		<b>9. AGE</b> (In years last birthday) <b>55</b> yrs. <table border="1" style="display: inline-table; border-collapse: collapse;"> <tr> <td colspan="2">IF UNDER 1 YEAR</td> <td colspan="2">IF UNDER 24 HRS.</td> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.															
Months	Days	Hours	Min.														
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Self-employed barber</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Barbering</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <b>Massachusetts</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>									
<b>13. FATHER'S NAME</b> <b>Unknown</b>				<b>14. MOTHER'S MAIDEN NAME</b> <b>Unknown</b>													
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No,</b>		<b>16. SOCIAL SECURITY NO.</b> <b>060-10-4901</b>		<b>17. INFORMANT</b> <span style="float: right;">Address</span> <b>Mr. James Alfred Avirett 1, Cumb. Md. Washington St.</b>													
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary ; Occlusion</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary sclerosis</b> DUE TO (c) _____								INTERVAL BETWEEN ONSET AND DEATH <b>sudden</b> -----									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____								<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH.</b>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  													
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o. m.      p. m.      19		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)											
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.</b>																	
<b>ACTUAL SIGNATURE</b> <i>Benedict Skitarelic</i> <b>M.D.</b>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DATE SIGNED</b>									
<b>EXAMINER'S NAME (Type)</b> <b>Benedict Skitarelic, M.D.</b>				<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>				<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>Sept. 20, 1959</b>									
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <b>Burial</b>		<b>22b. DATE THEREOF</b> <b>9/22/59</b>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <b>Sunset Memorial Park</b>		<b>22d. LOCATION (City, town, or county)</b> (State) <b>Cumberland, Maryland</b>											
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <b>H. Wayne George</b>				<b>ADDRESS</b> <b>Cumberland, Md.</b>		<b>24a. REC'D BY REGISTRAR</b> <b>DATE SEP 23 '59</b>		<b>24b. REGISTRAR'S SIGNATURE</b> <i>Arthur E. Evans</i>									

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. Five pages 1 and 2 with the registrar prior to burial, cremation, or removal.



1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>ONE DAY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address and nearest town) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>BESSIE</b> <b>XXXXXX</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 3 1889</b>
9. AGE (In years lost birthday) <b>70</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GROCERY STORE OWNER</b>		12. KIND OF BUSINESS OR INDUSTRY <b>GROCERY</b>	
13. FATHER'S NAME <b>JAMES INSKEEP</b>		14. MOTHER'S MAIDEN NAME <b>ELIZABETH TRAVIS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Myocarditis</b> <b>422.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis</b> DUE TO (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>4-7-59</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. <b>—</b> p. m. <b>—</b> 19 <b>59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> NOT while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7/14/59</b> , 19 <b>59</b> , to <b>9/11/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9/11/59</b> , 19 <b>59</b> , and that death occurred at <b>7:05 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>DR. RICHARD J. WILLIAMS</b>		DATE SIGNED <b>9/13/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-14-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Wesley Chapel Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Points, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		24a. REC'D BY REGISTRAR <b>SEP 17 '59</b>	
ADDRESS <b>Cumberland, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>William S. Kline</b>	

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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ISM 9/5B

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5330 · J. Neurosci., July 26, 2006 · 26(30):5323–5334

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09804

CERTIFICATE OF DEATH

Reg. Dist. No.

09735

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Midland</b>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Railroad Street</b>		d. STREET ADDRESS <b>Railroad Street</b>	
3. NAME OF DECEASED (Type or print) <b>CHESTER</b> First Middle Last		4. DATE OF DEATH <b>9/21.1959</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/25/ 1895</b>
9. AGE (In years last birthday) <b>64</b> yrs.		IF UNDER 1 YEAR: Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Celanese Employee</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <b>Midland, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Elijah Davis</b>		14. MOTHER'S MAIDEN NAME <b>Hannah Boor</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Mrs. Hannah Davis, Midland, MD.</b> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hypertensive Cardiovascular Disease</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Dis.</b> (c) <b>1 day</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9/21/59</b> , 19 <b>59</b> , to <b>9/21/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9/21/59</b> , 19 <b>59</b> , and that death occurred at <b>9:30 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>2 Broadway Frostburg Md.</b> DATE SIGNED			
ACTUAL SIGNATURE <b>John B. Davis, M.D.</b>			
PHYSICIAN'S NAME (Type) <b>John B. Davis, M.D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/23/1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b> ADDRESS <b>LONACONING, MD.</b>		24a. REC'D BY REGISTRAR <b>SEP 25 '59</b>	24b. REGISTRAR'S SIGNATURE <b>John B. Davis</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



2

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1  
 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 09761  
 CERTIFICATE OF DEATH

09736

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>X</b> <b>Cresaptown</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Martha</b> Middle <b>E</b> Last <b>Dawson</b>		4. DATE OF DEATH Month <b>9</b> Day <b>17</b> Year <b>1959</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9-11-1883</b>	9. AGE (In years lost birthday) yrs. <b>76</b>	IF UNDER 1 YEAR Months <b>6</b> Days <b>17</b> Hours <b>15</b> Min.	IF UNDER 24 HRS. Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland Dawson</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
13. FATHER'S NAME <b>Dawson, Theodore</b>				14. MOTHER'S MAIDEN NAME <b>Taylor, Susan</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None</b>		INFORMANT <b>Mrs. Solomon Doss</b> <b>Daughter Cresaptown, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerosis heart disease</b> <b>420.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>						INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 14, 1959</b> to <b>Sept 17, 1959</b> that I last saw the deceased alive on <b>Sept 14, 1959</b> and that death occurred at <b>4:31 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>43 Greene Street, Cumberland, Md</b> DATE SIGNED <b>9-19-59</b>							
ACTUAL SIGNATURE <b>B. M. Schindler</b>		M.D. <b>43 Greene Street, Cumberland, Md</b>					
PHYSICIAN'S NAME (Type) <b>Dr. B. M. Schindler M.D.</b>		<b>43 Greene Street, Cumberland, Md</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 20, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 22 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>	

1350

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 4, 21 Film G249 9-28-59 et

09762

CERTIFICATE OF DEATH

09737

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>Lifetime</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>		d. STREET ADDRESS <b>111 Oak St.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>111 Oak St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>James</b> Middle <b>Waldron</b> Last <b>Day</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>15</b> Year <b>1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 11, 1891</b>
9. AGE (In years, less birthday) yrs. <b>67</b>		IF UNDER 1 YEAR: Months <b>16</b> Days <b>15</b> Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Painter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James H. Day</b>		14. MOTHER'S MAIDEN NAME <b>Jessie Mudge</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>yes WAR I</b>		16. SOCIAL SECURITY NO. <b>705-09-9883</b>	
17. INFORMANT <b>Mrs. James Day, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Colon</b> <b>153.8</b> DUE TO <b>Metastasis to Liver -</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>—</b> (c) <b>—</b>		INTERVAL BETWEEN ONSET AND DEATH <b>2 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <b>19</b> p. m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Cumh Alleg Md</b> (County) (State)	
21. I certify that I attended the deceased from <b>7/2/54</b> , 19 <b>54</b> , to <b>9/15/59</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9/15/59</b> , 19 <b>59</b> , and that death occurred at <b>10:42 P.M.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Richard J. Williams</b> M.D.		ADDRESS (Street, city or town, state) <b>122 S. Centre St.</b> DATE SIGNED	
PHYSICIAN'S NAME (Type) <b>Richard J. Williams, MD.</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-19-1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 21 '59</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09738

1 ~~X~~  
FOR STATE  
HEALTH DEPT.

Reg. Dist. No.

09763

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u> c. LENGTH OF STAY IN 1b <u>69 Dc.</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland, Maryland</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Memorial Hosp.</u>		d. STREET ADDRESS <u>23 Laing Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Frederick W. Frost</u>		4. DATE OF DEATH <u>Sept. 12 1959</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 15, 1887</u>
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Laundry Worker Union Laundry</u>		11b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Frederick Frost</u>	
14. MOTHER'S MARDEN NAME <u>Mary Dennyowski</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mrs. Dolphin Bucy. Cumb. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Artery Disease</u> DUE TO <u>Arteriosclerosis</u> Conditions, if any, which gave rise to immediate cause (b) <u>Arteriosclerosis</u> DUE TO <u>Arteriosclerosis</u> causing the underlying cause lost. (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Colitis - Fracture of ankle</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>It was intopicated &amp; fell down stair</u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hours a. m. <u>7/5/59</u> p. m.	20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home 23 Laing Ave. Cumberland Md.</u>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>J. Williams</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/16/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Greenmont Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc. Cumb. Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 16 59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kenna</u>		DATE	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.





MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
 09764  
 CERTIFICATE OF DEATH

09739

Reg. Dist. No.

1. PLACE OF DEATH COUNTY ALLEGANY MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND		c. LENGTH OF STAY IN 1b 7 HOURS	
d. NAME OF HOSPITAL (If not in hospital, give street address) MEMORIAL HOSPITAL AVE.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First KENNETH Middle S. Last FULLER		4. DATE OF DEATH Month SEPTEMBER Day 10 Year 1959	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH JULY 1, 1906
9. AGE (In years last birthday) 53 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired Machinist		10b. KIND OF BUSINESS OR INDUSTRY Textile, Yarn	
11. BIRTHPLACE (State or foreign country) CUMBERLAND, MARYLAND		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME HARRY, FULLER		14. MOTHER'S MAIDEN NAME ELIZABETH KRAUSE	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 214-07-2965	
17. INFORMANT No		Address MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 411X DUE TO CONGESTIVE HEART FAILURE (b) HORTIC INSUFFICIENCY (c) DUE TO OLD RHEUMATIC HEART DISEASE PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) UPPER RESP. INFECT. OLD RT HEMIPARESIS		INTERVAL BETWEEN ONSET AND DEATH 3 days 154 hrs UNKNOWN	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 1946 to Sept 10 1959 that I last saw the deceased alive on Sept 10 1959, and that death occurred at 5:00 M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Allevenson		ADDRESS (Street, city or town, state) 59 GREENE ST CUMBERLAND, MD	
PHYSICIAN'S NAME (Type) S G WEISMAN		DATE SIGNED 9/12/59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 9-13-59	
22c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park		22d. LOCATION (City, town, or county) (State) Cumberland, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli		24a. REC'D BY REGISTRAR DATE SEP 17 '59	
ADDRESS Cumberland, Md		24b. REGISTRAR'S SIGNATURE William J. Krause	

CERTIFICATE OF BIRTH

MASSACHUSETTS

WILMINGTON, MASSACHUSETTS

WILMINGTON HOSPITAL

1900

WILMINGTON

WILMINGTON

WILMINGTON, MASSACHUSETTS

WILMINGTON

WILMINGTON HOSPITAL

WILMINGTON

09805

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany County</u> <u>Lonaconing</u> <u>all</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md.</u> b. COUNTY <u>all</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Lonaconing</u>	
c. LENGTH OF STAY IN 1b <u>years</u>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Roosevelt Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>Wilmoth</u> First <u>Garlitz</u> Middle <u>Barlitz</u> Last		4. DATE OF DEATH <u>Sept. 20</u> 19 <u>59</u> Month Day Year	
5. SEX <u>m</u>	6. COLOR OR RACE <u>wh.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/2/1900</u> 9. AGE (In years last birthday) <u>59</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Celanese Corp.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>flexible</u>	11. BIRTH PLACE (State or foreign country) <u>Huilton, MD</u>
13. FATHER'S NAME <u>Othea Garlitz</u>		14. MOTHER'S MAIDEN NAME <u>Annabel Durst</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>214-07-3264</u>	
17. INFORMANT <u>Mrs. Wilmoth Garlitz</u> Address <u>Lonaconing, Md.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary occlusion</u> 420.1 DUE TO <u>arteriosclerotic cardiovascular dis.</u> years Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause lost. (b) <u>arteriosclerosis</u> (c) <u>arteriosclerosis</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Sudden death</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. <u>19</u> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>March</u> , 19 <u>55</u> to <u>Sept</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>21st</u> , 19 <u>59</u> , and that death occurred at <u>2 A</u> M, from the causes and on the date stated above.	
ACTUAL SIGNATURE <u>George Vash</u> M.D. <u>27, Main Street</u>		ADDRESS (Street, city or town, state) <u>Lonaconing, Md.</u> DATE SIGNED	
PHYSICIAN'S NAME (Type) <u>George Vash</u>			
22a. BURIAL, CREMATION, or other disposal (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St. Marys Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Lonaconing, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>George Eichhorn</u> ADDRESS <u>Lonaconing, Md.</u>		24a. REC'D BY REGISTRAR <u>SEP 23 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kline</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00340

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

## CERTIFICATE OF DEATH

19802

1. Name of deceased: **WILLIAM B. BROWN**

2. Date of death: **10/10/80**

3. Place of death: **Home**

4. Age at death: **78**

5. Sex: **M**

6. Race: **W**

7. Marital status: **M**

8. Occupation: **Retired**

9. Cause of death: **Heart Disease**

10. Date of burial: **10/15/80**

11. Place of burial: **St. Mary's Cemetery**

12. Signature of physician: **Dr. J. A. Smith**

13. Signature of registrar: **John Doe**

14. Date of registration: **10/12/80**

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 4 Film 6249 10-1-59 et

09741

09765

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>1/9/1956</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Lillian Belle Grady</b>		4. DATE OF DEATH Month Day Year <b>Sept. 22, 19 59</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/4/1889</b>
9. AGE (In years last birthday) yrs. <b>70</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Winfield Porter</b>		14. MOTHER'S MAIDEN NAME <b>Hattie Albright</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT <b>P.O.Box 599</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary-vascular disease &amp; advanced</b> <b>422.1</b> DUE TO <b>arterio sclerosis.</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Gastric hemorrhage -</b> DUE TO (c) <b>Gastric hemorrhage -</b>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1/9/56</b> , 19____, to <b>9/22/59</b> , 19____, that I last saw the deceased alive on <b>9/22/59</b> , 19____, and that death occurred at <b>4:35 P</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>9/23/59</b> ACTUAL SIGNATURE <b>L. B. Mathews</b> M.D. PHYSICIAN'S NAME (Type) <b>Dr. L. B. Mathews</b> <b>Cumberland, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 25, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Patricks Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Mt. Savage, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer</b>		ADDRESS <b>Cumberland, Maryland</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 28 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur A. Thomas</b>	

CERTIFICATE OF DEATH

1958

Name of Deceased Maryland		Sex Male	
Date of Birth 1915		Place of Birth Maryland	
Date of Death 1958		Place of Death Maryland	
Cause of Death Heart Disease		Manner of Death Natural	
Occupation Farmer		Usual Residence Maryland	
Signature of Physician [Signature]		Signature of Registrar [Signature]	
Date of Certificate 1958		Place of Issuance Maryland	



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09742

09766

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>				c. LENGTH OF STAY IN 1b <u>40th 55th St.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>				d. STREET ADDRESS <u>243 N. Centre St.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Emma</u> Middle <u>Margaret</u> Last <u>Gramlich</u>				4. DATE OF DEATH Month <u>9</u> Day <u>26</u> Year <u>1959</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-7-1860</u>	
9. AGE (In years last birthday) yrs. <u>99</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		11. IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>		11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Richard Bender</u>				14. MOTHER'S MAIDEN NAME <u>Mary (Gesner)</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>			
17. INFORMANT <u>Miss Marie E. Glick</u>				Address <u>Cumb. Md. 243 N. Centre St.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> <u>33/X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Vascular Accident, right cerebral hemisphere</u> DUE TO (c) <u>Generalized and Cerebral Arteriosclerosis</u> INTERVAL BETWEEN ONSET AND DEATH <u>2-3 hours</u> <u>3 days</u> <u>years</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>February 1958</u> to <u>Sept. 26th, 1959</u> , that I last saw the deceased alive on <u>Sept. 26th, 1959</u> , and that death occurred at <u>12:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Algonquin Hotel, Cumberland, Maryland.</u> DATE SIGNED <u>9/27/59</u>							
ACTUAL SIGNATURE <u>Wyand F. Doerner, Jr.</u>				M.D. <u>Algonquin Hotel, Cumberland, Maryland.</u>			
PHYSICIAN'S NAME (Type) <u>Wyand F. Doerner, Jr., M.D.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/29/59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter &amp; Paul's</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. Wayne George</u>				ADDRESS <u>Cumberland, Maryland</u>		24a. REC'D BY REGISTRAR <u>SEP 29 1959</u>	
24b. REGISTRAR'S SIGNATURE <u>Charles E. Brand</u>							



FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09743

09806

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oldtown</b>		c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Ellerslie</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS <b>Gardner Avenue</b>	
3. NAME OF DECEASED (Type or print) <b>KENNETH L. GRIFFEY</b>			4. DATE OF DEATH <b>Sept. 26</b> Month <b>19</b> Day <b>59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 27, 1892</b>	9. AGE (in years last birthday) <b>67</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Carpenter</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Rayon factory</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Charles Griffey</b>			14. MOTHER'S MAIDEN NAME <b>Emma E. Coleman</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>214 07 4249</b>		17. INFORMANT <b>Linwood Griffey</b> Address <b>Ellerslie, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Sclerosis</b> DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/29/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>	
22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>		ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 28 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

LOS ANGELES  
HEALTH DEPT.

City of Los Angeles  
Health Department  
Office of the City Health Officer  
100 South Main Street  
Los Angeles, California

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09744

09767

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b> c. LENGTH OF STAY IN 1b <b>02 Cumberland,</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hosp.</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland,</b> d. STREET ADDRESS <b>627 Frederick St.,</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>JAMES</b> First <b>EDWARD</b> Middle <b>HARPER</b> Last		4. DATE OF DEATH Month <b>Sept.</b> Day <b>7,</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 31, 1869</b>
9. AGE (In years) <b>90</b> Months Days Hours Min.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired wood turner</b>	
11. BIRTHPLACE (State or foreign country) <b>Gore, Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Harper</b>		14. MOTHER'S MAIDEN NAME <b>Mary F. Light</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>No,</b>		16. SOCIAL SECURITY NO. <b>No,</b>	
17. INFORMANT <b>Mrs. May H. Minghini</b>		Address <b>Cumberland, Md. 627 Frederick St.,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture RT hip</b> DUE TO <b>904.0</b> Conditions, if any, which gave rise to immediate cause (b) <b>Fracture of age and</b> (a), stating the underlying cause last. (c) <b>fracture of age and</b>		INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Pneumonia and anemia</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II, item 18.) <b>Spelling in bath room</b>	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <b>9/3/59</b> p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) <b>Cumberland, Md.</b> (County) <b>Allegany</b> (State) <b>Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>R. J. Williams</b> EXAMINER'S NAME (Type) <b>R. J. Williams M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>(acting)</b> DATE SIGNED <b>9/10/59</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/11/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cemetery</b>		22d. LOCATION (City, town, or county) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b> ADDRESS <b>Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 10 '59</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hines</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be retained by the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1928

NAME OF DECEASED: \_\_\_\_\_  
AGE: \_\_\_\_\_ SEX: \_\_\_\_\_  
DATE OF DEATH: \_\_\_\_\_ PLACE OF DEATH: \_\_\_\_\_

CAUSE OF DEATH: \_\_\_\_\_  
MANNER OF DEATH: \_\_\_\_\_

DATE OF EXAMINATION: \_\_\_\_\_  
PLACE OF EXAMINATION: \_\_\_\_\_

SIGNATURE OF EXAMINER: \_\_\_\_\_  
TITLE OF EXAMINER: \_\_\_\_\_

DATE OF SIGNATURE: \_\_\_\_\_  
PLACE OF SIGNATURE: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_  
PLACE OF DEATH: \_\_\_\_\_

DATE OF EXAMINATION: \_\_\_\_\_  
PLACE OF EXAMINATION: \_\_\_\_\_

SIGNATURE OF EXAMINER: \_\_\_\_\_  
TITLE OF EXAMINER: \_\_\_\_\_

DATE OF SIGNATURE: \_\_\_\_\_  
PLACE OF SIGNATURE: \_\_\_\_\_

DATE OF DEATH: \_\_\_\_\_  
PLACE OF DEATH: \_\_\_\_\_

DATE OF EXAMINATION: \_\_\_\_\_  
PLACE OF EXAMINATION: \_\_\_\_\_

SIGNATURE OF EXAMINER: \_\_\_\_\_  
TITLE OF EXAMINER: \_\_\_\_\_

DATE OF SIGNATURE: \_\_\_\_\_  
PLACE OF SIGNATURE: \_\_\_\_\_



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09768

CERTIFICATE OF DEATH

09745

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>WEST VIRGINIA</b> b. COUNTY <b>MINERAL</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>7 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street or institution) <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>Elizabeth</b> Last <b>HARRISON</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>7,</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>WHITE</b>	
7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 29, 1886</b>	
9. AGE (In years lost birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <b>73</b> Days <b>73</b> Hours <b>73</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND, Cumberland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>EDENHART, CHARLES</b>		14. MOTHER'S MAIDEN NAME <b>NICKEL, ANNA</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Ca of stomach</b> <b>151X</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) <b>Pernicious anemia</b> DUE TO (c) <b>1 year</b> <b>8 years</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>8 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Terminal cerebral thrombosis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>7 - 8</b> , 19 <b>54</b> , to <b>9 - 7</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9 - 7</b> , 19 <b>59</b> , and that death occurred at <b>10:10 PM</b> , from the causes and on the date stated above.		ADDRESS (Street, city or town, state) <b>62 Greene St.</b> DATE SIGNED <b>9-9-59</b>	
ACTUAL SIGNATURE <b>Ralph L. Ballin</b>		M.D. <b>62 Greene St.</b>	
PHYSICIAN'S NAME (Type) <b>DR. RALPH BALLIN MD.</b>		Cumberland, Md.	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/10/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>SEP 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraw</b>	

00758

CENTINIA OF DEATH

00758

INTERVIEW

WEST VIRGINIA

ALLEGANY

DEPT. OF HEALTH

1 DAY

INTERVIEW

GENERAL HOSPITAL, WASHINGTON, D.C.

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WASHINGTON, D.C.

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GENERAL HOSPITAL

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09746

09769

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	c. LENGTH OF STAY IN <b>Life</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>		d. STREET ADDRESS <b>Route 4, Mexico Farms</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>ERNEST E. HARTMAN, JR.</b>		4. DATE OF DEATH <b>Sept. 29, 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 7, 1922</b>
9. AGE (In years last birthday) <b>36 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brakeman</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>W. M. R. R.</b>	11. BIRTHPLACE (State or foreign country) <b>Maryland</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Ernest E. Hartman, Sr.</b>	
14. MOTHER'S MAIDEN NAME <b>Bertha Beerman</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>Yes WW 2</b>	
16. SOCIAL SECURITY NO. <b>217 18 4865</b>		17. INFORMANT <b>E. E. Hartman, Sr. Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crushed Chest, Ruptured Liver</b> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Automobile Accident</b> DUE TO (c)			INTERVAL BETWEEN ONSET AND DEATH <b>10-15 Min</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH? <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Automobile Accident</b>	
20c. TIME OF INJURY Month, Day, Year <b>4:10 a.m. Sept. 29 19 59</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rt. #220</b>	20f. (City or town) (County) (State) <b>On Rt. 22, Bedford, Pa.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>Benedict Skitarelic</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M. D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>9/30/1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>Oct. 2, 1959</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cem.</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Knight</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR <b>OCT 2 '59</b>		24b. REC'D BY REGISTRAR <b>OCT 2 '59</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Allegany

Life

Cumberland

Eastern State Hospital

House 1, Mexico Farms

WEST

E. H. HARTMAN, JR.

Nov. 7, 1932

Female

Nov. 7, 1932

35

W. A. P. B.

Allegany

Bethesda Hospital

Dr. E. H. HARTMAN, JR.

Yes

Nov. 7, 1932

E. H. HARTMAN, JR. Cumberland, Md.

Organized Chest, Inflamed Liver

Automobile Accident

Automobile Accident

Nov. 7, 1932

ON RAIL, Bethesda, Md.

9/11/32

Benjamin S. Kistler, M.D.

Byron Elmer

Cumberland, Md.

Oct. 2, 1932

Dr. E. H. HARTMAN, JR.

Cumberland, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09770

## CERTIFICATE OF DEATH

Item 4 Film 6249 10/5/59 1wk

Reg. Dist. No.

09747

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland Md.</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>511 Richd Ave</u>		d. STREET ADDRESS <u>1511 Richd Ave</u>	
3. NAME OF DECEASED (Type or print) First <u>William</u> Middle <u>S.</u> Last <u>Helmstetter</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>24</u> Year <u>19 59</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 28, 1896</u>
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired Watchman</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>B &amp; O.</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Helmstetter</u>		14. MOTHER'S MAIDEN NAME <u>Sabine Rahnig</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes or unknown) <u>No.</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>Mrs. Bertha Jones</u> Address <u>Cumb. Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Myocarditis with Decompensation</u> <u>422.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO (c) <u>—</u> INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9-21, 19-59</u> to <u>9-24, 19-59</u> , that I last saw the deceased alive on <u>9-21, 19-59</u> , and that death occurred at <u>6:00 AM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>16 Greene St. Cumberland Md.</u> DATE SIGNED <u>10-9-59</u>			
ACTUAL SIGNATURE <u>James J. Johnson</u>		PHYSICIAN'S NAME (Type) <u>James W. Johnson Jr.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9/28/59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter &amp; Paul Ch.</u>		22d. LOCATION (City, town, or county) (State) <u>Cumberland Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Louis Stein Inc.</u> ADDRESS <u>Cumb. Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 29 '59</u>	
		24b. REGISTRAR'S SIGNATURE <u>Arthur A. Hanna</u>	



CERTIFICATE OF DEATH

60570

1. SEX OF DECEASED Male		2. RACE OF DECEASED White		3. AGE OF DECEASED 65	
4. DATE OF DEATH 1917		5. PLACE OF DEATH Home		6. CITY OR TOWN OF DEATH Baltimore	
7. COUNTY OF DEATH Baltimore		8. NAME OF DECEASED John Doe		9. NAME OF DECEASED John Doe	
10. NAME OF DECEASED John Doe		11. NAME OF DECEASED John Doe		12. NAME OF DECEASED John Doe	
13. NAME OF DECEASED John Doe		14. NAME OF DECEASED John Doe		15. NAME OF DECEASED John Doe	
16. NAME OF DECEASED John Doe		17. NAME OF DECEASED John Doe		18. NAME OF DECEASED John Doe	
19. NAME OF DECEASED John Doe		20. NAME OF DECEASED John Doe		21. NAME OF DECEASED John Doe	
22. NAME OF DECEASED John Doe		23. NAME OF DECEASED John Doe		24. NAME OF DECEASED John Doe	
25. NAME OF DECEASED John Doe		26. NAME OF DECEASED John Doe		27. NAME OF DECEASED John Doe	
28. NAME OF DECEASED John Doe		29. NAME OF DECEASED John Doe		30. NAME OF DECEASED John Doe	
31. NAME OF DECEASED John Doe		32. NAME OF DECEASED John Doe		33. NAME OF DECEASED John Doe	
34. NAME OF DECEASED John Doe		35. NAME OF DECEASED John Doe		36. NAME OF DECEASED John Doe	
37. NAME OF DECEASED John Doe		38. NAME OF DECEASED John Doe		39. NAME OF DECEASED John Doe	
40. NAME OF DECEASED John Doe		41. NAME OF DECEASED John Doe		42. NAME OF DECEASED John Doe	
43. NAME OF DECEASED John Doe		44. NAME OF DECEASED John Doe		45. NAME OF DECEASED John Doe	
46. NAME OF DECEASED John Doe		47. NAME OF DECEASED John Doe		48. NAME OF DECEASED John Doe	
49. NAME OF DECEASED John Doe		50. NAME OF DECEASED John Doe		51. NAME OF DECEASED John Doe	
52. NAME OF DECEASED John Doe		53. NAME OF DECEASED John Doe		54. NAME OF DECEASED John Doe	
55. NAME OF DECEASED John Doe		56. NAME OF DECEASED John Doe		57. NAME OF DECEASED John Doe	
58. NAME OF DECEASED John Doe		59. NAME OF DECEASED John Doe		60. NAME OF DECEASED John Doe	
61. NAME OF DECEASED John Doe		62. NAME OF DECEASED John Doe		63. NAME OF DECEASED John Doe	
64. NAME OF DECEASED John Doe		65. NAME OF DECEASED John Doe		66. NAME OF DECEASED John Doe	
67. NAME OF DECEASED John Doe		68. NAME OF DECEASED John Doe		69. NAME OF DECEASED John Doe	
70. NAME OF DECEASED John Doe		71. NAME OF DECEASED John Doe		72. NAME OF DECEASED John Doe	
73. NAME OF DECEASED John Doe		74. NAME OF DECEASED John Doe		75. NAME OF DECEASED John Doe	
76. NAME OF DECEASED John Doe		77. NAME OF DECEASED John Doe		78. NAME OF DECEASED John Doe	
79. NAME OF DECEASED John Doe		80. NAME OF DECEASED John Doe		81. NAME OF DECEASED John Doe	
82. NAME OF DECEASED John Doe		83. NAME OF DECEASED John Doe		84. NAME OF DECEASED John Doe	
85. NAME OF DECEASED John Doe		86. NAME OF DECEASED John Doe		87. NAME OF DECEASED John Doe	
88. NAME OF DECEASED John Doe		89. NAME OF DECEASED John Doe		90. NAME OF DECEASED John Doe	
91. NAME OF DECEASED John Doe		92. NAME OF DECEASED John Doe		93. NAME OF DECEASED John Doe	
94. NAME OF DECEASED John Doe		95. NAME OF DECEASED John Doe		96. NAME OF DECEASED John Doe	
97. NAME OF DECEASED John Doe		98. NAME OF DECEASED John Doe		99. NAME OF DECEASED John Doe	
100. NAME OF DECEASED John Doe		101. NAME OF DECEASED John Doe		102. NAME OF DECEASED John Doe	

RECEIVED BY THE DEPARTMENT

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18



09771

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>4 DAYS</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>				e. STREET ADDRESS <b>RT. #2, Williams Road</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>HERBERT</b> Middle <b>B.</b> Last <b>HIGSON</b>				4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>7</b> Year <b>19 59</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MARCH 16, 1912</b>		9. AGE (In years last birthday) yrs. <b>47</b>	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>STEGMAIER'S FARM</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>General Farming</b>		11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA Keyser</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>HARRY HIGSON</b>				14. MOTHER'S MAIDEN NAME <b>MAUDE DOUGLING</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>217-10-1277</b>		INFORMANT Address <b>WARWICK &amp; MEMORIAL AVES. CUMBERLAND, MARYLAND.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal cardiac failure</b> 593X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Uremia</b> DUE TO (c) <b>Nephritis</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>INTERVAL BETWEEN ONSET AND DEATH</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>9/1/59</b> to <b>9/7/59</b> , that I lost saw the deceased alive on <b>9/7/59</b> , and that death occurred at <b>4:10 AM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>DR. G. M. SIMONS</b> M.D.				ADDRESS (Street, city or town, state) <b>Williams Road</b> DATE SIGNED <b>9/11/59</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 10, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Mt. Herman Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Allegany Co., Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 11 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hafer</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

ALLERGY

WYLAND

COMETAL

1940

RECEIVED HOSPITAL

MALE

WHITE

HARRY JONES

1940

1940

1940

1940

1940

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1940

1940

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09749

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>50 years</b> d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>VIRGIL D. HINKLE</b>		4. DATE OF DEATH <b>Sept. 17, 19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 14, 1897</b>
9. AGE (In years last birthday) <b>62</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Weighmaster</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>	
11. BIRTHPLACE (State or foreign country) <b>Elkins, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Philmore H. Hinkle</b>		14. MOTHER'S MAIDEN NAME <b>Mary Virginia Wentling</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>705 05 8089</b>	
17. INFORMANT <b>Mrs. Juanita McKenzie, Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> 420.1 DUE TO <b>Coronary Artery disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <b>Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>30 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>—</b>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year <b>10:20 a.m. 9/17/59</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cummb Alley Md</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>[Signature]</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Byron Kight</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 20, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Byron Kight</b>		24a. REC'D BY REGISTRAR <b>SEP 21 '59</b>	
ADDRESS <b>Cumberland, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be filed to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: For: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED MRS. MARY ANN BROWN		AGE 50 years		SEX Female	
RESIDENCE 1234 Maple Ave. Baltimore, Md.		OCCUPATION Housewife		EDUCATION High School	
DATE OF DEATH Jan. 15, 1927		PLACE OF DEATH Home		CAUSE OF DEATH Heart Disease	
MANNER OF DEATH Natural		MEDICAL HISTORY None		POST-MORTEM None	
SIGNATURE OF EXAMINER J. H. Smith		DATE Jan. 15, 1927		PLACE Baltimore, Md.	
OFFICE OF EXAMINER Baltimore, Md.		COUNTY Baltimore		STATE Maryland	

09796

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>4 Months</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mabel</b> Middle <b>L.</b> Last <b>Hitchins</b>				4. DATE OF DEATH September 19th, 1959			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 17th, 1879</b>	9. AGE (In years last birthday) <b>80</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired teacher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School Teaching</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Hitchins</b>				14. MOTHER'S MAIDEN NAME <b>Sallie Brown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>—</b>		INFORMANT <b>64 W. College Ave., Mrs. Rachel Dunn, Frostburg, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> DUE TO <b>Arterio Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>General</b> (c) <b>years</b>						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>May 15, 1959</b> to <b>Sept 19, 1959</b> , that I lost s/he the deceased alive on <b>Sept 19, 1959</b> , and that death occurred at <b>10:30 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>W. O. McLane</b> M.D.				ADDRESS (Street, city or town, state) <b>167 E. Main Street, Frostburg, Md.</b>			
PHYSICIAN'S NAME (Type) <b>W. O. McLane</b>				DATE SIGNED <b>Sept 21, 1959</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-22-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park,</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>				24a. REC'D BY REGISTRAR <b>SEP 23 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Charles E. House</b>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

00750

00750

RECORDS OF DEATH

11-1-1917

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11-1-1917



09773

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland.</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland.</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>801 Mann's Terrace</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>ELLA</b> Middle <b>ISABELLE</b> Last <b>HOLTZHOOR</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>10</b> Year <b>1959</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 18, 1873</b>	
9. AGE (In years last birthday) <b>85</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Sunbury, Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>John Clymer</b>				14. MOTHER'S MAIDEN NAME <b>Catherine A. Holter</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>No,</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mr. Clifton J. Goodrich</b> Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Terminal Cardiac Failure</b> <b>443X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Hypertensive arteriosclerosis Heart Disease 5 years</b> (c) <b>Gen. arteriosclerosis</b>				INTERVAL BETWEEN ONSET AND DEATH <b>24 hours</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>15 June</b> , 19 <b>55</b> , to <b>10 Sept.</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9 Sept.</b> , 19 <b>59</b> , and that death occurred at <b>4:30</b> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>122 So. Centre St.,</b> DATE SIGNED <b>11 Sept. 59</b> ACTUAL SIGNATURE <b>W. Alfred Van Ormer</b> M.D. PHYSICIAN'S NAME (Type) <b>W. A. VanOrmer M.D.</b> <b>Cumberland, Md.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/13/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b> ADDRESS <b>Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>SEP 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kline</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 10/57

CERTIFICATE OF DEATH

<p>NAME OF DECEASED                  [REDACTED]</p>		<p>AGE                  [REDACTED]</p>	
<p>SEX                  [REDACTED]</p>		<p>RACE                  [REDACTED]</p>	
<p>DATE OF BIRTH                  [REDACTED]</p>		<p>PLACE OF BIRTH                  [REDACTED]</p>	
<p>DATE OF DEATH                  [REDACTED]</p>		<p>PLACE OF DEATH                  [REDACTED]</p>	
<p>CAUSE OF DEATH                  [REDACTED]</p>		<p>IMMEDIATE CAUSE                  [REDACTED]</p>	
<p>INTERMEDIATE CAUSE                  [REDACTED]</p>		<p>UNDERLYING CAUSE                  [REDACTED]</p>	
<p>DATE OF EXAMINATION                  [REDACTED]</p>		<p>PLACE OF EXAMINATION                  [REDACTED]</p>	
<p>SIGNATURE OF PHYSICIAN                  [REDACTED]</p>		<p>SIGNATURE OF REGISTRAR                  [REDACTED]</p>	
<p>DATE OF SIGNATURE                  [REDACTED]</p>		<p>DATE OF SIGNATURE                  [REDACTED]</p>	

1  
HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18									
Item 18 Film 248 9-9-59 ams									
09774									
CERTIFICATE OF DEATH									
Reg. Dist. No. 09752									
1. PLACE OF DEATH a. COUNTY ALLEGANY b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND c. LENGTH OF STAY IN 1b 5 hours d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MEMORIAL HOSPITAL-WARWICK AVES.					2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND b. COUNTY ALLEGANY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) CUMBERLAND d. STREET ADDRESS 732 BAKER STREET e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First BABY Middle BOY Last HUFFMAN					4. DATE OF DEATH Month SEPTEMBER Day 1, Year 1959				
5. SEX MALE		6. COLOR OR RACE WHITE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH AUG. 31, 1959		9. AGE (In years last birthday) yrs. 5 35	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) none			10b. KIND OF BUSINESS OR INDUSTRY none			11. BIRTHPLACE (State or foreign country) CUMBERLAND, MD.		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME BURREL HUFFMAN					14. MOTHER'S MAIDEN NAME GEORGIA J. ROTRUCK				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no					16. SOCIAL SECURITY NO. none				
17. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 754.1 DUE TO A miotic (megamiotic) proliferation of entire lining of paracystoma (b) Patent ductus arteriosus? (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 5 hrs					18. INFORMANT WARWICK & MEMORIAL AVES. MEMORIAL HOSPITAL, CUMBERLAND, MARYLAND.				
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)					20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I attended the deceased from Aug 1, 1959 to Sept 1, 1959, that I last saw the deceased alive on Sept 1, 1959, and that death occurred at 2:45 AM from the causes and on the date stated above. WR Hodges M.D. Cumberland, Md 9/1/59									
ACTUAL SIGNATURE PHYSICIAN'S NAME (Type) DR. HODGES & MOULD.					DATE SIGNED Cumberland, Md 9/1/59				
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial			22b. DATE THEREOF 9-1-1959		22c. NAME OF CEMETERY OR CREMATORY Huffman Family Cemetery			22d. LOCATION (City, town, or county) (State) Flintstone, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE James F. Scarpelli, Cumberland, Md.					24a. REC'D BY REGISTRAR DATE SEP 3 '59		24b. REGISTRAR'S SIGNATURE Arthur S. Hines		

2060291XV5

CERTIFICATE OF DEATH

NAME

RESIDENCE

DATE OF DEATH

AGE

SEX

RACE

EDUCATION

CAUSE OF DEATH

PLACE OF DEATH

DECEASED'S SIGNATURE

DECEASED'S SIGNATURE

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DECEASED'S SIGNATURE

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME  
5M 2/57

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
09807 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09753

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. # 1 Cumberland,</b>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rt. # 1 Cumberland,</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Valley Road</b>			d. STREET ADDRESS <b>Valley Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>EMMA</b> Middle <b>MARIA</b> Last <b>IMLER</b>			4. DATE OF DEATH Month <b>Sept.</b> Day <b>10,</b> Year <b>1959</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 4, 1863</b>	9. AGE (In years last birthday) <b>95</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Bedford Co. Penna.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
13. FATHER'S NAME <b>Daniel Dibert</b>			14. MOTHER'S MAIDEN NAME <b>Maria Croyle</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT Address <b>Mrs. Agnes Hensley, Rt. # 1 Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis</b> (c) <b>Ravages of age</b> causes lost.					INTERVAL BETWEEN ONSET AND DEATH <b>slight</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>None</b>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>None</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Cumt. City, Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>R. J. Williams M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>9/10/59</b>	
EXAMINER'S NAME (Type) <b>R. J. Williams M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Arthur L. Hensley</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/12/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Pleasant Valley Cem.</b>	
22d. LOCATION (City, town, or county) <b>Nr. Bedford, Penna.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur L. Hensley</b>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>Charles L. George Cumberland, Md.</b>					

MEDICAL CERTIFICATION

2



STATE OF MARYLAND

DEPARTMENT OF HEALTH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04753

Form with multiple sections for medical examination and death certification, including fields for name, age, sex, race, and cause of death. The form is oriented horizontally but contains vertical text labels.

NAME: [illegible]  
AGE: [illegible]  
SEX: [illegible]  
RACE: [illegible]  
DATE OF BIRTH: [illegible]  
PLACE OF BIRTH: [illegible]  
DATE OF DEATH: [illegible]  
PLACE OF DEATH: [illegible]  
CAUSE OF DEATH: [illegible]  
MANNER OF DEATH: [illegible]  
SIGNATURE: [illegible]  
DATE: [illegible]



may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09775

CERTIFICATE OF DEATH

Reg. Dist. No.

09754

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>TOLIVER</b> Middle <b>WADE</b> Last <b>JEWELL</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>23</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 13, 1880</b>
9. AGE (In years last birthday) <b>79</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired laborer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>	
11. BIRTHPLACE (State or foreign country) <b>Rockingham Co. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>EMANUEL JEWELL (DECEASED)</b>		14. MOTHER'S MAIDEN NAME <b>Susan Zoughlin (DECEASED)</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No,</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>217-10-6677</b>	
17. ADDRESS <b>Mr. Lester L. Jewell 937 Md. Ave., Cumb. Md.</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>arteriosclerotic heart disease</b> 420.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>generalized arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b> <b>2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>4-3-</b> , 19 <b>57</b> , to <b>9-23</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9-23-</b> , 19 <b>59</b> , and that death occurred at <b>11:00 P.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <b>9-25-59</b> ACTUAL SIGNATURE <b>Lewis Brings</b> M.D. _____ PHYSICIAN'S NAME (Type) <b>Lewis Brings, M.D.</b> <b>55 GREENE ST., CUMBERLAND, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/26/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>		24a. REC'D BY REGISTRAR <b>SEP 28 '59</b>	
ADDRESS <b>Cumberland, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. Hume</b>	

05704

CERTIFICATE OF DEATH

05704

1. Name of deceased

2. Sex

3. Age

4. Date of death

5. Place of death

6. Cause of death

7. Signature of physician

8. Signature of registrar

9. Date of registration

10. Place of registration

11. Name of registrar

12. Signature of registrar

13. Date of registration

14. Place of registration

15. Name of registrar

16. Signature of registrar

17. Date of registration

18. Place of registration

19. Name of registrar

20. Signature of registrar

21. Date of registration

22. Place of registration

Reg. Dist. No.

VS. A15ME  
SM 2/57

1. PLACE OF DEATH a. COUNTY <b>Allegany</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY in lb <b>35yrs</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland 02</b>		d. STREET ADDRESS <b>1804 Oldtown Road</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>1804 Oldtown Road</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Effie</b>		First <b>Caroline</b>		Middle <b>Kellar</b>		Last	
4. DATE OF DEATH <b>Sept. 7,</b>		Month		Day		Year <b>1959</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 17, 1886</b>		9. AGE (In years last birthday) <b>72</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (State or foreign country) <b>Salem, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Geo. A. Davis</b>		14. MOTHER'S MAIDEN NAME <b>Melvina Boyce</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Beryl E. Kellar</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cerebral Sclerosis</b> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>8 hrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <b>Richard J. Williams, MD</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>8/7/59</b>	
EXAMINER'S NAME (Type)				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (acting)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-10-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Zion Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>		ADDRESS		24a. REC'D BY REGISTRAR <b>SEP 10 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carbur &amp; House</b>	

100

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09808

## CERTIFICATE OF DEATH

09756

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Md.</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>La Vale -Rural</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Route Cumberland</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Route # 40</b>		d. STREET ADDRESS <b>820 Oldtown Road</b>	
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>Keith</b> Last <b>Kelley</b>		4. DATE OF DEATH Month <b>Sept</b> Day <b>13</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 1, 1901</b>
9. AGE (In years lost birthday) <b>58</b> yrs.		10. IF UNDER 1 YEAR Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min. <b>58</b>	11. IF UNDER 24 HRS. Months <b>58</b> Days <b>58</b> Hours <b>58</b> Min. <b>58</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Paper Mill</b>	
11. BIRTHPLACE (State or foreign country) <b>Beryl, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Archibald Kelley</b>		14. MOTHER'S MAIDEN NAME <b>Sarah Scott</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>216-07-8871</b>	
INFORMANT <b>Bessie Kelley-Cumberland, Md.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Coronary Artery Disease</b> (c) <b>Coronary Artery Disease</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>5-24-1957</b> , to <b>9-13-1959</b> that I last saw the deceased alive on <b>5-7-1959</b> , and that death occurred at <b>11:30 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Wm. F. Williams</b> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <b>Cumberland Md 9-15-59</b>	
PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/16/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>E. J. Bural</b>		ADDRESS <b>Westernport, Md.</b>	24a. REC'D BY REGISTRAR <b>SEP 17 '59</b>
24b. REGISTRAR'S SIGNATURE <b>Calvin A. Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

82808

82808

Form with multiple lines for text entry, including fields for name, date, and location. The form is mostly blank with some faint, illegible markings.

1





## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09757

09777

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN 1b <b>3/16/59</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Allegany County Infirmary</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Clara</b> Middle <b>Lillian</b> Last <b>Kerber</b>		4. DATE OF DEATH Month <b>September</b> Day <b>10</b> Year <b>1959</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/11/1873</b>
9. AGE (In years last birthday) yrs. <b>85</b>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>	
11. BIRTHPLACE (State or foreign country) <b>Frostburg, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>William Beane</b>		14. MOTHER'S MAIDEN NAME <b>Kathryn Brennan</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>P.O. Box 599</b>		Address <b>Cumberland, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Hypertosis</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Myocardial Degeneration</b> DUE TO (c) <b>General arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 hrs.</b> ? ?	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Osteoarthritis</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>3/16/59</b> , 19____, to <b>9/10/59</b> , 19____, that I last saw the deceased alive on <b>9/10/59</b> , 19____, and that death occurred at <b>7:05 P.M.</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>49 Greene St.</b> DATE SIGNED <b>9/11/59</b>			
ACTUAL SIGNATURE <b>James E. McLean</b> M.D.		DATE SIGNED <b>9/11/59</b>	
PHYSICIAN'S NAME (Type) <b>Dr. James E. McLean</b>		<b>Cumberland, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/12/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>SS. Peter &amp; Paul's</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles L. George</b>		ADDRESS <b>Cumberland, Md.</b>	
24a. REC'D BY REGISTRAR DATE <b>SEP 14 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Rouse</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



09797

## CERTIFICATE OF DEATH

Reg. Dist. No.

09758

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg,</b>		c. LENGTH OF STAY IN lb <b>25 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>54 Ormand Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Joseph T. Kidwell</b>		4. DATE OF DEATH Month Day Year <b>Sept. 18th, 1959</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 10th, 1911</b>
9. AGE (In years last birthday) <b>48</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Foreman-Spinning</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp.</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Kidwell</b>		14. MOTHER'S MAIDEN NAME <b>Janet Gracie</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>214-07-5355</b>	
17. INFORMANT <b>Mrs. Margaret Kidwell, Frostburg, Md.</b>		Address <b>54 Ormand St.,</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute myocardial infarction</b> 420.1 DUE TO <b>Coronary Sclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) <b>?</b> (c)		INTERVAL BETWEEN ONSET AND DEATH <b>20 min</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Sept 18, 1959</b> , to <b>Sept 18, 1959</b> , that I last saw the deceased alive on <b>Sept 18, 1959</b> , and that death occurred at <b>12:30 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>WOM Lane</b> M.D.		ADDRESS (Street, City or town, state) <b>Frostburg Sept 18 1959</b>	
PHYSICIAN'S NAME (Type) <b>WOM Lane</b>		DATE SIGNED <b>Sept 18 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-21-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst,</b> ADDRESS <b>Frostburg, Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 21 '59</b>	
		24b. REGISTRAR'S SIGNATURE <b>Arthur G. Knaus</b>	

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS AIS (4)  
ISM 9/58



1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

097759

09778

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>19 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital give street address) OR IN <b>MEMORIAL HOSPITAL</b> <b>MEMORIAL &amp; WARWICK AVES.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>RACHEL</b> Middle <b>C.</b> Last <b>KROWE</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>17</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>NOVEMBER 13, 1876</b>
9. AGE (In years last birthday) yrs. <b>82</b>		10. IF UNDER 1 YEAR Months <b>02</b> Days <b>02</b> Hours <b>02</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housekeeper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>HENRY SIMONS</b>		14. MOTHER'S MAIDEN NAME <b>SARA SIMONS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> Address <b>MEMORIAL HOSPITAL CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> <b>450.0</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Congestive Failure</b> DUE TO (c) <b>Generalized Arteriosclerosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>1 wk</b> <b>2 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-13</b> , 19 <b>59</b> , to <b>9-17</b> , 19 <b>59</b> that I last saw the deceased alive on <b>9-17-59</b> , 19 <b>59</b> , and that death occurred at <b>3:40 P.</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>441 1/2 Center St Cumberland Md</b> DATE SIGNED <b>9-18-59</b>			
ACTUAL SIGNATURE <b>William P. James</b> M.D.		PHYSICIAN'S NAME (Type) <b>DR. WILSON HIMMELWRIGHT</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/20/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Ruth E. Silcox</b>		24a. REC'D BY REGISTRAR <b>SEP 24 '59</b>	
ADDRESS <b>Cumberland Maryland</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur J. Hume</b>	

00750

STATEMENT OF DEATH

00770

NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH  
AGE  
SEX  
RACE  
MARRIAGE  
EDUCATION  
OCCUPATION  
RELIGION  
CAUSE OF DEATH  
MANNER OF DEATH  
SIGNATURE OF DECEASED  
SIGNATURE OF WITNESSES  
SIGNATURE OF MINISTER  
SIGNATURE OF CLERK

1

STATEMENT OF DEATH  
NAME OF DECEASED  
DATE OF DEATH  
PLACE OF DEATH  
AGE  
SEX  
RACE  
MARRIAGE  
EDUCATION  
OCCUPATION  
RELIGION  
CAUSE OF DEATH  
MANNER OF DEATH  
SIGNATURE OF DECEASED  
SIGNATURE OF WITNESSES  
SIGNATURE OF MINISTER  
SIGNATURE OF CLERK



09779

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>W.VA.</u> b. COUNTY <u>Mineral</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ridgeley, 85 X-3</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Sacred Heart Hospital</u>		d. STREET ADDRESS <u>12 Jones St.</u>	
3. NAME OF DECEASED (Type or print) First <u>Regina</u> Middle <u>Lucille</u> Last <u>Lechlitter</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>20</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct. 30, -1943</u>
9. AGE (In years last birthday) <u>15</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own home</u>	
11. BIRTHPLACE (State or foreign country) <u>Cumberland, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George D. Shaffer</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jones</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>	
INFORMANT <u>Mr. John L. Lechlitter</u>		Address <u>Ridgeley, W.Va. 12 Jones St.,</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Serum Hepatitis</u> <u>951X</u> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>under-</u> lying cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>9/15</u> , 19 <u>59</u> , to <u>9/20</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>9/20</u> , 19 <u>59</u> , and that death occurred at <u>4:50 P.</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Dr. L. H. Ley Jr.</u>		ADDRESS (Street, city or town, state) <u>412 N. Centre St. Cumberland, Md.</u>	
PHYSICIAN'S NAME (Type) <u>Dr. Leo H. Ley</u>		DATE SIGNED <u>9/21/59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/23/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Zion Memorial Cem.</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Maryland</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Charles L. George</u>		ADDRESS <u>Cumberland, Md.</u>	
24a. REG. BY REGISTRAR <u>SEP 24 59</u>		24b. REGISTRAR'S SIGNATURE <u>Charles L. George</u>	

CERTIFICATE OF DEATH

1970

1

1970

1970

09798

## CERTIFICATE OF DEATH

Reg. Dist. No.

09761

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>FROSTBURG</b>		c. LENGTH OF STAY IN 1b <b>70 Yrs.</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>42 LINDEN ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>MARION</b> Middle <b>G.</b> Last <b>LEWIS</b>		4. DATE OF DEATH Month <b>SEPT.</b> Day <b>25</b> Year <b>19 59</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JAN. 10, 1866</b>
9. AGE (In years last birthday) <b>93</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWORK</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>OWN HOME</b>	
11. BIRTHPLACE (State or foreign country) <b>WALES</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>DAVID GRIFFITH</b>		14. MOTHER'S MAIDEN NAME <b>MARY YATES</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NONE</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b> <b>GRIFFITH LEWIS, FROSTBURG, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>450.0</b> <b>arterio sclerosis</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <b>3 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>1956</b> , 19 <b>Sept 25</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept 25</b> , 19 <b>59</b> , and that death occurred at <b>7:15 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>E. MAIN ST., FROSTBURG, MD.</b> DATE SIGNED <b>Sept 26 1959</b> ACTUAL SIGNATURE <b>W. O. McLane</b> M.D. PHYSICIAN'S NAME (Type) <b>W. O. McLANE, M. D.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	22b. DATE THEREOF <b>SEPT. 28 '59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>F'BG. MEMORIAL PARK</b>	22d. LOCATION (City, town, or county) (State) <b>FROSTBURG, MD.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>I. R. DURST, FROSTBURG, MD.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 28 '59</b>	24b. REGISTRAR'S SIGNATURE <b>Arthur L. Frank</b>

1

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

CERTIFICATE OF DEATH

1. NAME OF DECEASED

2. AGE

3. SEX

4. RACE

5. PLACE OF BIRTH

6. DATE OF BIRTH

7. PLACE OF DEATH

8. CAUSE OF DEATH

9. MANNER OF DEATH

10. SIGNATURE OF DECEASED

11. SIGNATURE OF WITNESSES

12. SIGNATURE OF MINISTER

13. SIGNATURE OF CLERGYMAN

14. SIGNATURE OF JUDGE

15. SIGNATURE OF SHERIFF

09780

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>Lifetime</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>608 Columbia Avenue</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mollie</u> Middle <u>Maihl</u> Last <u>Maihl</u>		4. DATE OF DEATH Month <u>Sept.</u> Day <u>24</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Aug. 20, 1874</u>
9. AGE (In years last birthday) <u>85</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	IF UNDER 24 HRS. Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Self Employed</u>	11. BIRTHPLACE (State or foreign country) <u>Cumberland, Md.</u>
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		13. FATHER'S NAME <u>John Maihl</u>	
14. MOTHER'S MAIDEN NAME <u>Margaret Dietrich</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Miss Mamie Dietrich, Cumberland, Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>450.0</u> DUE TO <u>Chlamydia</u> Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Corticosteroid</u> DUE TO (c) <u>  </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>			INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>10 yrs</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u>  </u> p. m. <u>  </u> 19 <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <u>Sept. 22, 1959</u> to <u>Sept. 24, 1959</u> , that I last saw the deceased alive on <u>Sept. 22, 1959</u> , and that death occurred at <u>11:35</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Clay E. Durrett</u> M.D.		ADDRESS (Street, city or town, state) <u>236 Virginia Ave. Cumberland, Md.</u> DATE SIGNED <u>9-25-1959</u>	
PHYSICIAN'S NAME (Type) <u>Clay E. Durrett, MD</u>		<u>Cumberland, Md.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9-29-1959</u>	22c. NAME OF CEMETERY OR CREMATORY <u>SS. Peter &amp; Paul Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Cumberland, Md.</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>SEP 29 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kane</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

JANUARY STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

0-2708

DATE OF DEATH

DECEASED

PLACE HERE THE NAME OF THE DECEASED

PLACE HERE THE ADDRESS OF THE DECEASED

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09781

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland,</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>513 Rose Hill Ave.,</b>				d. STREET ADDRESS <b>513 Rose Hill Ave.,</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <b>MAUDE</b> Middle <b>ESSIE</b> Last <b>MATHEWS</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>24,</b> Year <b>19 59</b>					
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Oct. 10, 1893</b>	9. AGE (In years last birthday) <b>65</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own home</b>		11. BIRTHPLACE (State or foreign country) <b>Sharpsburg, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>Emory D. Gray</b>				14. MOTHER'S MAIDEN NAME <b>Fannie M. Benner</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No,</b>		16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Mrs. Myrtle Brode</b> Address <b>Cumberland, Md.</b> <b>511 Rose Hill Ave.,</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> DUE TO 181.0 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma of Urinary Bladder</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>6 Months</b> <b>18 Months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Aug. 31</b> , 19 <b>59</b> , to <b>Sept. 24</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>Sept. 24</b> , 19 <b>59</b> , and that death occurred at <b>7:55 P.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>126 N. Smallwood St., Cumberland, Md.</b> DATE SIGNED <b>25 Sept 59</b>							
ACTUAL SIGNATURE <b>L. Michael Glick</b>		M.D. <b>126 N. Smallwood St., Cumberland, Md.</b>					
PHYSICIAN'S NAME (Type) <b>L. Michael Glick, M.D.</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/27/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>H. Wayne George</b>				ADDRESS <b>Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 28 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Orlino &amp; Kenna</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09764

09782

CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>20 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SAMUEL</b> Middle <b>MC</b> Last <b>CUTCHEON</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>3</b> Year <b>19 59</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>MAY 17 1884</b>
9. AGE (In years last birthday) <b>75</b> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Coal Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>MARYLAND</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>SAMUEL MC CUTCHEON</b>		14. MOTHER'S MAIDEN NAME <b>FANNY JACOBS</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>	
17. INFORMANT <b>MEMORIAL HOSPITAL</b>		Address <b>CUMBERLAND, MD.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebro-Vascular Accident (Embolus)</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) <b>Aricular Fibrillation</b> DUE TO (c) <b>Coronary Arteriosclerosis; Myocardial Fibrosis</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Immediate</b> <b>??</b> <b>??</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>Had Cerebro Vascular Accident (embolus) August 14, 1959</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State) <b>Cumberland, Maryland</b>	
21. I certify that I attended the deceased from <b>August 14, 1959</b> , to <b>September 3, 1959</b> , that I last saw the deceased alive on <b>September 3, 1959</b> , and that death occurred at <b>11:40 AM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>50 Pershing Street</b> DATE SIGNED <b>9/1/59</b>			
ACTUAL SIGNATURE <b>[Signature]</b> M.D.			
PHYSICIAN'S NAME (Type) <b>Dr. George M. Jacobson</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9.6.1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Laurel Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Moscow, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>		ADDRESS <b>LONACONING, MD.</b>	
24a. REG'D BY REGISTRAR <b>SEP 8 59</b>		24b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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09799

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b X c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>"Rural" Frostburg</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miners Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>McNeil</b> Last <b>McNeil</b>		4. DATE OF DEATH Month <b>September</b> Day <b>14</b> Year <b>19 59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>November 8, 1873</b>
9. AGE (In years last birthday) yrs. <b>85</b>		IF UNDER 1 YEAR Months <b>14</b> Days <b>19</b> Hours <b>59</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Hampshire, W.Va</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William McNeil</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth O'Neil</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. (If yes, give war or dates of service) <b>664-07-4086</b>	
17. INFORMANT <b>Leo McNeil</b>		Address <b>Klondike, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac Failure</b> 442X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Cardiovascular Renal Disease</b> DUE TO (c) <b>Partial Gastric obstruction</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH <b>2 wks.</b> <b>months</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Feb. 19 58</b> to <b>Sept. 14, 19 59</b> , that I last saw the deceased alive on <b>Sept 14, 19 59</b> , and that death occurred at <b>1:25 PM</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>John B. Davis</b> M.D.		ADDRESS (Street, city or town, state) <b>2 Broadway</b> DATE SIGNED <b>9/14/59</b>	
PHYSICIAN'S NAME (Type) <b>John B. Davis, MD</b>		<b>Frostburg, Md.</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9/16/59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>George Eichhorn</b>		ADDRESS <b>Lonaconing, Maryland</b>	
24a. REC'D BY REGISTRAR <b>SEP 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached far use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09766

09783

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>ONE DAY</b>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL WARWICK &amp; MEMORIAL AVES.</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
4. DATE OF DEATH First Middle Last <b>MICHAEL OLIN MILLER</b>				4. DATE OF DEATH Month Day Year <b>SEPTEMBER 7, 19 59</b>					
5. SEX <b>MALE</b>		6. COLOR OR RACE <b>WHITE</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>JUNE 30, 1952</b>			
9. AGE (In years lost birthday) <b>7 yrs.</b>		10. UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>				10b. KIND OF BUSINESS OR INDUSTRY					
13. FATHER'S NAME <b>MILLER, ROBERT O.</b>				14. MOTHER'S MAIDEN NAME <b>TUCKER, RUTH LEE</b>					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>					
17. INFORMANT <b>MEMORIAL HOSPITAL -CUMBERLAND, MD.</b>				Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bulbar Polio</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>080.0</b> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <b>18 hours</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)					
21. I certify that I attended the deceased from <b>Sept 5, 1959</b> to <b>Sept 7, 1959</b> , that I last saw the deceased alive on <b>Sept 7, 1959</b> , and that death occurred at <b>6:00 PM</b> from the causes and on the date stated above.									
ACTUAL SIGNATURE <b>Dr. Overton G. Himmelwright</b>				ADDRESS (Street, city or town, state) <b>133 Virginia Ave</b>					
PHYSICIAN'S NAME (Type) <b>DR. OVERTON G. HIMMELWRIGHT</b>				DATE SIGNED <b>9/9/59</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-9-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Hillcrest Burial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>			
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>				ADDRESS <b>Cumberland, Md.</b>					
24a. REC'D BY REGISTRAR DATE <b>SEP 14 '59</b>				24b. REGISTRAR'S SIGNATURE <b>Arthur L. Kraus</b>					

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

09767

09809

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, near Cumberland</b>		c. LENGTH OF STAY IN 1b <b>3 mos</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural, near Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Route 4, Willowbrook Road</b>			d. STREET ADDRESS <b>Route 4, Willowbrook Road</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>CHARLES</b> First <b>MAXWELL</b> Middle <b>MITCHELL</b> Last			4. DATE OF DEATH <b>September 14</b> Month <b>14</b> Day <b>19</b> Year <b>59</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 3, 1932</b>		9. AGE (In years, month, day, hour, min.) <b>26</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Textile Wkr.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Celanese Corp. of</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>	
13. FATHER'S NAME <b>Thomas M. Mitchell</b>			14. MOTHER'S MAIDEN NAME <b>Mary Davis</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>yes Korean Conflict</b>		16. SOCIAL SECURITY NO. <b>215-26-9892</b>		17. INFORMANT <b>Mrs. Mary Davis Mitchell</b> Address <b>Rt. 4 Cumberland, Md</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>acute Cranial Hemorrhage</b> DUE TO <b>by gun shot wound</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c) INTERVAL BETWEEN ONSET AND DEATH <b>immediate</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Gun shot wound head -</b>			
20c. TIME OF INJURY Month, Day, Year <b>9/14/59</b> Hour <b>1:30</b> a.m. <input type="checkbox"/> p.m. <input type="checkbox"/>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	
20f. City or town <b>Cumh Alleg Md</b>		20g. (County) <b>Allegany</b>		20h. (State) <b>Md</b>	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Richard J. Williams</b>		M.D. <b>Richard J. Williams</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>Richard J. Williams</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <b>Sept. 15, 1959</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/19/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Mem. Park</b>	
22d. LOCATION (City, town, or county) <b>Cumberland, Maryland</b>		22e. (State) <b>Md</b>		22f. ADDRESS <b>Cumberland, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer</b>		24a. REC'D BY REGISTRAR <b>SEP 17 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Carlton E. Kline</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09810

## CERTIFICATE OF DEATH

Reg. Dist. No.

09768

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		c. LENGTH OF STAY IN 1b <b>78yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Lonaconing</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Castle Street</b>				d. STREET ADDRESS <b>Castle Street</b>			
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>KINGSLEY</b> Last <b>MORGAN</b>				4. DATE OF DEATH Month <b>9/13/1959</b> Day <b>19</b> Year <b>19</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>10/31/1880</b>		9. AGE (In years last birthday) <b>78</b> yrs.	IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Pipefitter</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Lonaconing, MD.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Esau Morgan</b>				14. MOTHER'S MAIDEN NAME <b>Rebecca Rinker</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>216-07-2720</b>		17. INFORMANT <b>Mrs. Nellie Morgan, Lonaconing, MD.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Occlusion, massive</b> <b>420.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Congestive Heart Failure</b>							INTERVAL BETWEEN ONSET AND DEATH <b>years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Dec.</b> 1955, to <b>Sept.</b> 1959, that I last saw the deceased alive on <b>Sept. 3</b> , 1959, and that death occurred at <b>1 a. m.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <b>Leslie R. Miles Jr.</b> M.D. <b>9.14.59</b>							
ACTUAL SIGNATURE		PHYSICIAN'S NAME (Type) <b>LESLIE R. MILES, JR., M.D.</b> <b>LONA CONING</b> <b>MD.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/15/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>				ADDRESS <b>LONA CONING? MD.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 15 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kiser</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

DECEASED NAME JAMES J. WILSON		SEX Male	
AGE 45		DATE OF BIRTH 1880	
PLACE OF BIRTH Boston, Mass.		OCCUPATION Carpenter	
MARITAL STATUS Married		DATE OF MARRIAGE 1905	
NAME OF DECEASED'S MOTHER Mary J. Wilson		NAME OF DECEASED'S FATHER John J. Wilson	
NAME OF DECEASED'S SPOUSE Elizabeth J. Wilson		DATE OF DEATH 1925	
PLACE OF DEATH Boston, Mass.		CAUSE OF DEATH Heart Disease	
PLACE OF INTERMENT St. James Cemetery		NAME OF INTERMENT SOCIETY St. James Cemetery Association	
NAME OF PHYSICIAN Dr. J. J. Smith		NAME OF BURIAL PLACE St. James Cemetery	
NAME OF REGISTRAR J. J. Smith		NAME OF CLERK J. J. Smith	

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

1925

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BOSTON

1925



09800

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>				c. LENGTH OF STAY IN 1b <b>6 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Miner's Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Mae</b> Middle <b>Desmond</b> Last <b>Muir</b>				4. DATE OF DEATH Month <b>September</b> Day <b>28th</b> Year <b>19 59</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Jan. 10th, 1886</b>		9. AGE (In years last birthday) <b>73 yrs.</b>	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own housework</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>John Willison</b>			
14. MOTHER'S MAIDEN NAME <b>Agnes Walkinshaw</b>				15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]			
16. SOCIAL SECURITY NO. <b>214-05-9925</b>				17. INFORMANT <b>Melvin Muir, Eckhart, Md.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral accident</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (c) <b>years -</b>							INTERVAL BETWEEN ONSET AND DEATH <b>3 Weeks</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>July</b> , 19 <b>47</b> , to <b>September 28</b> , 19 <b>59</b> that I last saw the deceased alive on <b>September 25</b> , 19 <b>59</b> , and that death occurred at <b>2:55 PM</b> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>John B. Davis</b> , M.D.				ADDRESS (Street, city or town, state) <b>2 Broadway,</b> DATE SIGNED			
PHYSICIAN'S NAME (Type) <b>John B. Davis</b>				" <b>Frostburg, Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Oct. 1st, 59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Eckhart Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Eckhart, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>				ADDRESS		24a. REC'D BY REGISTRAR DATE <b>OCT 2 '59</b>	
				24b. REGISTRAR'S SIGNATURE <b>Arthur A. Hume</b>			

Page 4

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death. The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registror prior to burial, cremation, or removal, and in any event within 72 hours after death.

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STATE OF TEXAS

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09770

09784

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>			c. LENGTH OF STAY IN 1b <b>1 day</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>717 North Mechanic Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>Raphael</b> Last <b>Nee</b>				4. DATE OF DEATH Month <b>September</b> Day <b>20</b> Year <b>1959</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 20, 1900</b>		
9. AGE (In years last birthday) <b>59</b> yrs.		10. FUND YEAR Months <b>59</b> Days <b>59</b> Hours <b>59</b> Min. <b>59</b>						
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Brewery Worker</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Cumberland Brew-</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Stephen Nee</b>				14. MOTHER'S MAIDEN NAME <b>Lucy O'Donnell</b>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>214-05-4830</b>		17. INFORMANT <b>Mrs. Dorothy Nee</b> Address <b>717 N. Mechanic Street</b>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1 Coronary Insufficiency and Occlusion, Marked</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerosis</b> (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Occlusion of iliac vessels due to atheromatous material. Died in</b> <b>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input checked="" type="checkbox"/></b> <b>20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)</b> <b>Automobile accident</b> <b>20c. TIME OF INJURY</b> Month, Day, Year <b>10:00 p.m. Sept. 19 1959</b> <b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/> <b>20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)</b> <b>Rt. #10</b> <b>20f. (City or town) (County) (State)</b> <b>Town Hill Alleg. Md.</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>								
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <b>Benedict Skitarelic</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>Benedict Skitarelic, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Sept. 20, 1959</b>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 23, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Pauls Cem</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>		
23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>				24a. REC'D BY REGISTRAR <b>SEP 23 59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur H. Frank</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED JOHN A. BAKER		2. SEX Male		3. AGE 65	
4. OCCUPATION Retired		5. MARITAL STATUS Married		6. PLACE OF BIRTH Boston, Mass.	
7. DATE OF DEATH 10/15/1941		8. TIME OF DEATH 10:30 AM		9. PLACE OF DEATH Home	
10. CAUSE OF DEATH Coronary artery disease		11. MANNER OF DEATH Natural		12. SIGNATURE OF EXAMINER [Signature]	
13. SIGNATURE OF ATTENDING PHYSICIAN [Signature]		14. SIGNATURE OF NEAREST RELATIVE [Signature]		15. SIGNATURE OF BURIAL OFFICIAL [Signature]	
16. SIGNATURE OF REGISTRAR [Signature]		17. SIGNATURE OF CLERK [Signature]		18. SIGNATURE OF JURY [Signature]	
19. SIGNATURE OF JURY [Signature]		20. SIGNATURE OF JURY [Signature]		21. SIGNATURE OF JURY [Signature]	
22. SIGNATURE OF JURY [Signature]		23. SIGNATURE OF JURY [Signature]		24. SIGNATURE OF JURY [Signature]	
25. SIGNATURE OF JURY [Signature]		26. SIGNATURE OF JURY [Signature]		27. SIGNATURE OF JURY [Signature]	
28. SIGNATURE OF JURY [Signature]		29. SIGNATURE OF JURY [Signature]		30. SIGNATURE OF JURY [Signature]	
31. SIGNATURE OF JURY [Signature]		32. SIGNATURE OF JURY [Signature]		33. SIGNATURE OF JURY [Signature]	
34. SIGNATURE OF JURY [Signature]		35. SIGNATURE OF JURY [Signature]		36. SIGNATURE OF JURY [Signature]	
37. SIGNATURE OF JURY [Signature]		38. SIGNATURE OF JURY [Signature]		39. SIGNATURE OF JURY [Signature]	
40. SIGNATURE OF JURY [Signature]		41. SIGNATURE OF JURY [Signature]		42. SIGNATURE OF JURY [Signature]	
43. SIGNATURE OF JURY [Signature]		44. SIGNATURE OF JURY [Signature]		45. SIGNATURE OF JURY [Signature]	
46. SIGNATURE OF JURY [Signature]		47. SIGNATURE OF JURY [Signature]		48. SIGNATURE OF JURY [Signature]	
49. SIGNATURE OF JURY [Signature]		50. SIGNATURE OF JURY [Signature]		51. SIGNATURE OF JURY [Signature]	
52. SIGNATURE OF JURY [Signature]		53. SIGNATURE OF JURY [Signature]		54. SIGNATURE OF JURY [Signature]	
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67. SIGNATURE OF JURY [Signature]		68. SIGNATURE OF JURY [Signature]		69. SIGNATURE OF JURY [Signature]	
70. SIGNATURE OF JURY [Signature]		71. SIGNATURE OF JURY [Signature]		72. SIGNATURE OF JURY [Signature]	
73. SIGNATURE OF JURY [Signature]		74. SIGNATURE OF JURY [Signature]		75. SIGNATURE OF JURY [Signature]	
76. SIGNATURE OF JURY [Signature]		77. SIGNATURE OF JURY [Signature]		78. SIGNATURE OF JURY [Signature]	
79. SIGNATURE OF JURY [Signature]		80. SIGNATURE OF JURY [Signature]		81. SIGNATURE OF JURY [Signature]	
82. SIGNATURE OF JURY [Signature]		83. SIGNATURE OF JURY [Signature]		84. SIGNATURE OF JURY [Signature]	
85. SIGNATURE OF JURY [Signature]		86. SIGNATURE OF JURY [Signature]		87. SIGNATURE OF JURY [Signature]	
88. SIGNATURE OF JURY [Signature]		89. SIGNATURE OF JURY [Signature]		90. SIGNATURE OF JURY [Signature]	
91. SIGNATURE OF JURY [Signature]		92. SIGNATURE OF JURY [Signature]		93. SIGNATURE OF JURY [Signature]	
94. SIGNATURE OF JURY [Signature]		95. SIGNATURE OF JURY [Signature]		96. SIGNATURE OF JURY [Signature]	
97. SIGNATURE OF JURY [Signature]		98. SIGNATURE OF JURY [Signature]		99. SIGNATURE OF JURY [Signature]	
100. SIGNATURE OF JURY [Signature]		101. SIGNATURE OF JURY [Signature]		102. SIGNATURE OF JURY [Signature]	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 2. See: Birth Cert. et

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frostburg</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Avilton</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Mine's Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>Parr</u> Last		4. DATE OF DEATH Month <u>Sept</u> Day <u>5</u> Year <u>1959</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept 3 1959</u>
9. AGE (In years last birthday) yrs. <u>1</u>		IF UNDER 1 YEAR Months <u>1</u> Days <u>2</u> IF UNDER 24 HRS. Hours <u>1</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <u>Frostburg Md</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Sammy Parr</u>		14. MOTHER'S MAIDEN NAME <u>Mary Jane Roberson</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <u>—</u>	
INFORMANT <u>Mary Jane Parr</u> Address <u>Avilton Md</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c):] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Prematurity - Congenital</u> DUE TO (b) <u>malformation of abdomen</u> DUE TO (c) <u>—</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>—</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>Sept 5 1959</u> to <u>Sept 5 1959</u> that I last saw the deceased alive on <u>Sept 5 1959</u> , and that death occurred at <u>1:15 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>WomcLare MD</u>		ADDRESS (Street, city or town, state) <u>Frostburg Md</u> DATE SIGNED <u>Sept 5 1959</u>	
PHYSICIAN'S NAME (Type) <u>WomcLare MD</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>9/7/59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>NEW GERMANY</u>	22d. LOCATION (City, town, or county) (State) <u>RURAL GRANTSVILLE MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Don Newman</u> ADDRESS <u>Grantsville Md</u>		24a. REC'D BY REGISTRAR <u>SEP 9 '59</u>	24b. REGISTRAR'S SIGNATURE <u>Arthur L. Knead</u>

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MAINTENANCE STATE OF MAINTENANCE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09773

09785

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>6 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL MEMORIAL &amp; WARWICK AVES.,</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>SUSAN</b> Middle Last <b>PRYOR</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>1</b> Year <b>1959</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>FEB. 24</b>
9. AGE (In years lost birthday) yrs. <b>81</b>		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (State or foreign country) <b>CUMBERLAND, MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>THOMAS BRIDENTHAWAL</b>		14. MOTHER'S MAIDEN NAME <b>HESTER ANN PRICE</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>None.</b>	
17. INFORMANT <b>MEMORIAL HOSPITAL CUMBERLAND, MD.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Car accident after</b> <b>156.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (c), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (c)		INTERVAL BETWEEN ONSET AND DEATH <b>6 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>Jan 15, 1959</b> , to <b>Aug 31, 1959</b> , that I last saw the deceased alive on <b>Aug 31, 1959</b> , and that death occurred at <b>8:30 AM</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>G. Overton Himmelfright</b>		ADDRESS (Street, city, or town, state) <b>1331a Ave, Cumberland, Md</b> DATE SIGNED <b>9/1/59</b>	
PHYSICIAN'S NAME (Type) <b>G. OVERTON HIMMELWRIGHT</b>			
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/3/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stern Inc.</b>		ADDRESS <b>Cumbr. Md</b>	
24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur S. Hines</b>	



# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09774

Reg. Dist. No.

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Allegany</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Maryland Route 55</u> c. LENGTH OF STAY IN 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RD 2, Frostburg</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Frederick</u> Middle <u>J.</u> Last <u>Rankin</u>			<b>4. DATE OF DEATH</b> Month <u>September</u> Day <u>17th</u> Year <u>19 59</u>				
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Sept. 16th, 1927</u>	9. AGE (In years last birthday) <u>32</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u> IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Bartender</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Moose Home</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>			
13. FATHER'S NAME <u>James Rankin</u>			14. MOTHER'S MAIDEN NAME <u>Mabel Gordon</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes, give war or dates of service) <u>W.W. 2</u>		16. SOCIAL SECURITY NO. <u>212-24-0219</u>		17. INFORMANT Address <u>Box 183</u> <u>Mrs. Mabel Rankin, RFD 2, Frostburg, Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured Skull - Frac left leg</u> DUE TO <u>823X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Laceration face &amp; shock</u> DUE TO <u>  </u> (c) <u>  </u>					INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>		
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>auto hit by car at high rate of speed and went over fence</u>					
20c. TIME OF INJURY Hour <u>6:15</u> p.m. Month, Day, Year <u>9/17/59</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>St Rt 55</u>	20f. (City or town) <u>Near Vale Summit Alleg. Md.</u>	(County) <u>  </u>	(State) <u>  </u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. J. Williams</u> EXAMINER'S NAME (Type) <u>R. J. Williams</u>			M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>acting</u>				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-20-59</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Porter Cemetery</u>		22d. LOCATION (City, town, or county) <u>Eckhart, Md.</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph R. Durst, Frostburg, Md.</u>			24a. REC'D BY REGISTRAR DATE <u>SEP 21 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Orlino S. Kraus</u>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please enclose the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.



## CERTIFICATE OF DEATH

Reg. Dist. No.

09786

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>2 DAYS</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>JOSEPH</b> Last <b>REINHARD</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>3</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APRIL 19, 1886</b>
9. AGE (In years last birthday) <b>73</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	11. IF UNDER 24 HRS. Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>PEPSI COLA BOTTLING CO.</b>	
11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>GEORGE A. REINHARD</b>		14. MOTHER'S MAIDEN NAME <b>ANNA LONG</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>INFORMANT</b>	
17. ADDRESS <b>MEMORIAL HOSPITAL</b>		18. ADDRESS <b>WARWICK &amp; MEMORIAL AVENUE CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage with left</b> <b>422.1</b> DUE TO <b>Congestive Heart Failure</b> Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause last. (b) <b>arteriosclerotic Cardiovascular Disease</b> (c) <b>Diabetes mellitus, sp. arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes mellitus, sp. arteriosclerosis</b> INTERVAL BETWEEN ONSET AND DEATH <b>9 hours</b> <b>3 days</b> <b>3 years</b>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1 pm.</b> , 19 <b>57</b> , to <b>3 Sept.</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>3 Sept.</b> , 19 <b>59</b> , and that death occurred at <b>11:07 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>122 S. Centre St.</b> DATE SIGNED <b>4 Sept. 1959</b> ACTUAL SIGNATURE <b>W. Alfred Van Ormer</b> M.D. <b>Cumberland, Md.</b> PHYSICIAN'S NAME (Type) <b>DR. W. A. VAN ORMER</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/7/59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>St. Peter &amp; Paul</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc. Cumb. Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 9 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Crispin &amp; Hines</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove cap and papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

248

0541736



**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**09787**  
**CERTIFICATE OF DEATH**

09777

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>Allegany</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>5 days</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				d. STREET ADDRESS <b>Rural</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Leonard</b> Middle <b>Wm</b> Last <b>Robertson</b>				4. DATE OF DEATH Month <b>Sept.</b> Day <b>18</b> Year <b>1959</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>3/13/14</b>	
9. AGE (In years last birthday) <b>45 yrs.</b>		10. IF UNDER 1 YEAR Months Days Hours Min.		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)	
13. FATHER'S NAME <b>Harrison Robertson</b>				14. MOTHER'S MAIDEN NAME <b>Laura Gracie</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>				16. SOCIAL SECURITY NO. <b>WW 12 233-44-5539</b>		INFORMANT Address <b>Pt's chart.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Generalized arteriosclerosis</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>year 1</b>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)							
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <b>May</b> , 19 <b>59</b> , to <b>Sept. 18</b> , 19 <b>59</b> that I last saw the deceased alive on <b>Sept. 14</b> , 19 <b>59</b> , and that death occurred at <b>M</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>43 Everett Avenue, Pk 179-59</b> DATE SIGNED <b>Sept. 14, 1959</b>							
ACTUAL SIGNATURE <b>B. M. Schneider</b> M.D.				PHYSICIAN'S NAME (Type) <b>B. M. Schneider</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 20, 1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Waxler</b>		22d. LOCATION (City, town, or county) (State) <b>Danville, Md</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Rogers Funeral Home</b>				ADDRESS <b>Keyser, S. Chalk</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Thomas</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

STATE OF TEXAS

1870

X

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09778

09812

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Maryland Route 55</b>			c. LENGTH OF STAY IN 1b <b>22</b> <b>Frostburg</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)			d. STREET ADDRESS <b>118 McCulloh St.</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) First <b>Robert</b> Middle <b>D.</b> Last <b>Seifarth</b>			4. DATE OF DEATH Month <b>September</b> Day <b>17th</b> , Year <b>1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 30th, 1919</b>	9. AGE (In years last birthday) <b>40</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Steel Const. Worker</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Bl'dg. Constr.</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Andrew Seifarth</b>			14. MOTHER'S MAIDEN NAME <b>Ruth Walsh</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>215-14-6373</b>		17. INFORMANT <b>Mrs. Edith C. Seifarth, Frostburg, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture both legs, side of chest &amp; shock</b> 823X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chest &amp; shock</b> DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Interval between onset and death</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto hit culvert at high rate of speed went end over end</b>			
20c. TIME OF INJURY Month, Day, Year Hour <b>6:15</b> p.m. <b>9/17/59</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>STATE Rtss Near Voke Summit - Alleg</b>	
20f. (City or town) (County) (State) <b>Frostburg, Alleg</b>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>R. J. Williams</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <b>9/17/59</b>	
EXAMINER'S NAME (Type) <b>R. J. Williams</b>		" ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
		" DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>Acting</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-20-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>F'b'g. Memorial Park</b>	
22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>					
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>			24a. REC'D BY REGISTRAR DATE <b>SEP 21 '59</b>		
			24b. REGISTRAR'S SIGNATURE <b>Arthur E. Kraus</b>		

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

10

STATE DEPARTMENT OF HEALTH  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10777

Name of Deceased		Sex		Age	
John J. Jones		Male		45	
Residence		Occupation		Cause of Death	
1012 Main St., Houston, Tex.		Carpenter		Myocardial Infarction	
Date of Death		Time of Death		Place of Death	
Jan 15, 1935		10:30 A.M.		Home	
Physician		Medical Examiner		Manner of Death	
Dr. J. H. Smith		J. H. Jones		Natural	
Signature of Medical Examiner		Signature of Physician		Signature of Coroner	
[Signature]		[Signature]		[Signature]	
Date of Certificate		Time of Certificate		Place of Certificate	
Jan 16, 1935		11:00 A.M.		Houston, Tex.	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09779

09789

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>2</u> years		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oldtown</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>35 South Street</u>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Florence Rebecca Shryock</u>				4. DATE OF DEATH Month <u>September</u> Day <u>28</u> Year <u>19 59</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 25 1874</u>		9. AGE (In years last birthday) <u>85</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>Town Creek, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Upton Athey</u>				14. MOTHER'S MAIDEN NAME <u>Sarah Athey</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>none</u>		17. INFORMANT <u>Mrs. Clara Buser</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Thrombosis</u> <u>450.0</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____						INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u> <u>15 yrs</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>June 19 56</u> to <u>Sept 28 19 55</u> , that I last saw the deceased alive on <u>Sept. 20 19 55</u> , and that death occurred at <u>3:00 P. M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>236 Virginia Ave. Cumberland, Maryland</u> DATE SIGNED _____ ACTUAL SIGNATURE <u>Clay E. Durrett</u> M.D. <u>236 Virginia Ave. Cumberland, Maryland</u> PHYSICIAN'S NAME (Type) <u>Clay E. Durrett</u> M.D. <u>236 Virginia Avenue, Cumberland, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>Sept. 30, 1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Shryock Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Town Creek, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Hafer, Cumberland, Maryland</u>				24a. REC'D BY REGISTRAR DATE <u>OCT 2 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Clara Buser</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09788

## CERTIFICATE OF DEATH

Reg. Dist. No.

09780

1. PLACE OF DEATH a. COUNTY <b>CUMBERLAND ALLEGANY</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>				c. LENGTH OF STAY IN 1b <b>10 HOURS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 CUMBERLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>SACRED HEART HOSPITAL</b>				d. STREET ADDRESS <b>224 S. LEE ST.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>FLORA</b> Middle <b>ESTELLA</b> Last <b>SMITH</b>				4. DATE OF DEATH Month <b>SEPT.</b> Day <b>19</b> Year <b>1959</b>			
5. SEX <b>FEMALE</b>		6. COLOR OR RACE <b>NEGRO</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>AUGUST 28, 1899</b>	
9. AGE (In years last birthday) <b>60</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>							
13. FATHER'S NAME <b>THOMAS COOK (DECEASED)</b>				14. MOTHER'S MAIDEN NAME <b>ELMIRE <del>SMITH</del> (DECEASED)</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, not or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>			
17. INFORMANT <b>PATIENTS CHART</b>				Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>175.0</b> <b>Cancer of the ovary</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>3-4</b> , 19 <b>57</b> , to <b>9-19</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>9-10</b> , 19 <b>59</b> , and that death occurred at <b>3:50 A.M.</b> from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED							
ACTUAL SIGNATURE <b>L. Brings</b> M.D.							
PHYSICIAN'S NAME (Type) <b>LEWIS BRINGS, M.D.</b>				<b>57 GREENE ST., CUMBERLAND, MARYLAND</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				22b. DATE THEREOF <b>9/21/59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Rose Hill Cem</b>	
22d. LOCATION (City, town, or county) (State) <b>Cumb. Md.</b>							
23. FUNERAL DIRECTOR'S SIGNATURE <b>Louis Stein Inc.</b>				ADDRESS <b>Cumb. Md.</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 23 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Evans</b>							

STATE OF NEW YORK  
CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Savage</b>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
c. LENGTH OF STAY IN 1b <b>45 Yrs.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Savage</b>		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION	
3. NAME OF DECEASED (Type or print) First <b>Frank</b> Middle <b>Snyder</b> Last <b>Snyder</b>		4. DATE OF DEATH Month <b>September</b> Day <b>1st</b> Year <b>1959</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>May 12th, 1889</b>	9. AGE (In years last birthday) <b>70 yrs.</b>	10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret.-oiler Spin.Dept.Celanese Corp.</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Snyder</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. <b>17-10-7385</b>		INFORMANT <b>Mrs. Margaret B. Snyder, Mt. Savage, Md.</b> Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma Pancreas</b> 157X DUE TO (b) <b>10 months</b> Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause last. (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>5/4</b> , 19 <b>59</b> , to <b>9/1</b> , 19 <b>59</b> , that I last saw the deceased alive on <b>8/30</b> , 19 <b>59</b> , and that death occurred at <b>2:30</b> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>48 Broadway</b> DATE SIGNED ACTUAL SIGNATURE <b>Hilda Jane Walters</b> M.D. PHYSICIAN'S NAME (Type) <b>Hilda Jane Walters</b> M.D. <b>Frostburg, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-4-59</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Methodist Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Mt. Savage, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b> ADDRESS		24a. REC'D BY REGISTRAR <b>SEP 4 1959</b> 24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kins</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

09213

Alameda

Alameda

of years

of years

of years

Frank

September 1st

1913

1913

Notified by Dr. J. H. Jones, Alameda, Cal.

Estimated age

Unknown

1913

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# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09782

09790

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Allegany</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Allegany</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Cumberland</u>		c. LENGTH OF STAY IN 1b <u>45 yrs.</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>02 Cumberland</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>D.O.A. Memorial Hospital</u>				d. STREET ADDRESS <u>1 410 Broadway</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Orlando</u> Middle <u>Ray</u> Last <u>Spangler</u>				4. DATE OF DEATH Month <u>Sept.</u> Day <u>8</u> Year <u>19 59</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>March 18, 1886</u>		9. AGE (In years last birthday) <u>73</u> yrs.		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Conductor-retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Railroad</u>		11. BIRTHPLACE (State or foreign country) <u>Huntington, W. Va.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Jeremiah Spangler</u>				14. MOTHER'S MAIDEN NAME <u>Sarah</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>705-09-7929</u>		17. INFORMANT Address <u>Mrs. Mae Spangler, Cumberland, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Coronary Artery Disease</u> (a), stating the underlying cause last. DUE TO (c) <u>  </u>						INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>  </u>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.) <u>none</u>					
20c. TIME OF INJURY Month, Day, Year Hour <u>8:30</u> <u>pm.</u> <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u> <u>  </u> <u>  </u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>Richard J. Williams, MD</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>9/10/59</u>	
EXAMINER'S NAME (Type) <u>Richard J. Williams, MD</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>Arthur L. Kraus</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>9-11-1959</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Terra Alta Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Terra Alta, W. Va.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James F. Scarpelli, Cumberland, Md.</u>				24a. REC'D BY REGISTRAR DATE <u>SEP 14 '59</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kraus</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

09783

09791

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <b>ALLEGANY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>1 DAY</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>		d. STREET ADDRESS <b>1 AUBURN AVENUE</b>	
3. NAME OF DECEASED (Type or print) First <b>CHARLES</b> Middle <b>W.</b> Last <b>TIPTON</b>		4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>11</b> Year <b>1959</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>AUGUST 1, 1910</b>
9. AGE (In years lost birthday) <b>49</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>#NONE Spinner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Textile, Yarn</b>	11. BIRTHPLACE (State or foreign country) <b>WEST VIRGINIA Blaine</b>
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>CHARLES TIPTON</b>	
14. MOTHER'S MAIDEN NAME <b>BERTHA BARNHART</b>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO. <b>214-07-5488</b>		INFORMANT <b>WARWICK &amp; MEMORIAL AVENUE</b> <b>MEMORIAL HOSPITAL - CUMBERLAND, MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.0 ACUTE MYOCARDIAL INFARCTION</b> DUE TO (b) <b>ARTERIOSCLEROTIC HEART DISEASE</b> DUE TO (c) <b>6 yrs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Old myocardial infarction - 1953</b>			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>1953</b> , to <b>Sept 11, 1959</b> , that I last saw the deceased alive on <b>Sept 11, 1959</b> , and that death occurred at <b>6:15 P.M.</b> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Stevenson</b>		DATE SIGNED <b>9/12/59</b>	
PHYSICIAN'S NAME (Type) <b>DR. WEISMAN</b>		ADDRESS (Street, city or town, state) <b>59 GREENE ST CUMBERLAND, MD</b>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>9-14-59</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Sunset Memorial Park</b>	22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli</b>		24a. REC'D BY REGISTRAR <b>SEP 17 '59</b>	
ADDRESS <b>Cumberland, Md.</b>		24b. REGISTRAR'S SIGNATURE <b>William J. Jones</b>	

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WEST VIRGINIA STATE DEPARTMENT OF HEALTH - EAST LANSING 10

CERTIFICATE OF DEATH

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WEST VIRGINIA STATE DEPARTMENT OF HEALTH - EAST LANSING 10

09792

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Mineral</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wiley Ford</b> <b>85x-3</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Sacred Heart Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print)		First <b>Bruce</b> Middle <b>H.</b> Last <b>Ward</b>		4. DATE OF DEATH Month <b>Sept.</b> Day <b>27</b> Year <b>1959</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/5/05</b>	9. AGE (In years last birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours	IF UNDER 24 HRS. Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Tire Repairman</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Tire Manuf. Co.</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va. - Short Gap</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
13. FATHER'S NAME <b>Unknown</b>				14. MOTHER'S MAIDEN NAME <b>Unknown</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO.		INFORMANT <b>Mrs. Bruce Ward, Wiley Ford, W. Va.</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>493X pneumonia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>7 days</b> DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>pneumonia, for bronchiectasis 1954</b>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <b>9-23-</b> 19 <b>59</b> , to <b>9-27-</b> 19 <b>59</b> , that I last saw the deceased alive on <b>9-26</b> 19 <b>59</b> , and that death occurred at <b>11:45 PM</b> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <b>57 Green St., Cumberland, Md.</b> DATE SIGNED <b>L Brings</b>							
ACTUAL SIGNATURE <b>L Brings</b>		M.D.					
PHYSICIAN'S NAME (Type) <b>Lewis Brings, M.D.</b>		<b>57 Green St., Cumberland, Md.</b>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-30-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fort Ashby Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Fort Ashby, W. Va.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>James F. Scarpelli, Cumberland, Md.</b>				24a. REC'D BY REGISTRAR DATE <b>OCT 5 1959</b>		24b. REGISTRAR'S SIGNATURE <b>Arthur E. King</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

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## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>				c. LENGTH OF STAY IN 1b <b>2 years</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>721 Lafayette Avenue</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>BROWSON</b> Last <b>WELLER</b>				4. DATE OF DEATH Month <b>September</b> Day <b>14</b> Year <b>19 59</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Sept. 26, 1876</b>	
9. AGE (In years last birthday) <b>82</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Engineer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>B &amp; O Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Fairview County, Penn.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Hezekiah Weller</b>		14. MOTHER'S MAIDEN NAME <b>Mary Ellen Allison</b>		Address <b>Montreal Avenue</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>Howard Weller Cumberland, Maryland</b>		17. INFORMANT <b>Howard Weller Cumberland, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>420.1</b> DUE TO <b>Coronary Thrombosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>myocarditis &amp; Decompensation</b> DUE TO (c) <b>3 yrs</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>3 yrs</b>	
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <b>19</b>	
20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <b>June 19 58</b> to <b>Sept 14 19 59</b> , that I last saw the deceased alive on <b>Sept. 12 19 59</b> , and that death occurred at <b>1300 P. M.</b> from the causes and on the date stated above.	
ACTUAL SIGNATURE <b>Clay E. Durrett</b>		M.D. <b>236 W. Lee Cumberland Md</b>		DATE SIGNED <b>9/17/59</b>		ADDRESS (Street, city or town, state)	
PHYSICIAN'S NAME (Type) <b>Clay E. Durrett, M.D.</b>		236 Virginia Avenue, Cumberland, Md.		22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>Sept. 18, 1959</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>Greenmount Cemetery</b>		22d. LOCATION (City, town, or county) (State) <b>Cumberland, Maryland</b>		23. FUNERAL DIRECTOR'S SIGNATURE <b>John J. Hafer, Cumberland, Maryland</b>		24a. REC'D BY REGISTRAR DATE <b>SEP 18 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur S. Kline</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

007982

NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 65		DATE OF BIRTH 1883		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE Married		EDUCATION High School		OCCUPATION Carpenter		RELIGION Methodist		RACE White	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PLACE OF DEATH Home		DATE OF DEATH 1945		TIME OF DEATH 10:30 AM	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF WITNESSES J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF NEXT OF KIN J. H. Harris		SIGNATURE OF CLERK J. H. Harris	
DATE OF DEATH 1945		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home		MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease	
NAME OF DECEASED JAMES H. HARRIS		SEX Male		AGE 65		DATE OF BIRTH 1883		PLACE OF BIRTH Baltimore, Md.	
MARRIAGE Married		EDUCATION High School		OCCUPATION Carpenter		RELIGION Methodist		RACE White	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		PLACE OF DEATH Home		DATE OF DEATH 1945		TIME OF DEATH 10:30 AM	
SIGNATURE OF PHYSICIAN J. H. Harris		SIGNATURE OF WITNESSES J. H. Harris		SIGNATURE OF DECEASED J. H. Harris		SIGNATURE OF NEXT OF KIN J. H. Harris		SIGNATURE OF CLERK J. H. Harris	
DATE OF DEATH 1945		TIME OF DEATH 10:30 AM		PLACE OF DEATH Home		MANNER OF DEATH Natural		CAUSE OF DEATH Heart Disease	



69802

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

FOR STATE  
HEALTH DEPT.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Frostburg</b>		c. LENGTH OF STAY IN 1b <b>6 Yrs.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>89½ Braddock Street</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John Robert Whetstone</b>		4. DATE OF DEATH Month <b>September</b> Day <b>24th</b> , 19 <b>59</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 12th, 1952</b>
9. AGE (In years last birthday) <b>6 yrs.</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>School Boy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James J. Whetstone</b>		14. MOTHER'S MAIDEN NAME <b>Betty James</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>89½ Braddock St., Frostburg, Md.</b>	
17. INFORMANT <b>James J. Whetstone</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Intercranial Hemorrhage Due To Gun Shot Wound - Point of Entry - Base of Nose Toward Rt Eye</b> DUE TO (b) <b>Sudden.</b> DUE TO (c) <b>Sudden.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased + Brother Playing with Rifle at their Home</b>	
20c. TIME OF INJURY Month, Day, Year <b>Sept 24 1959</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Near Frostburg Allegany Md</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>W.O. McLane</b>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) <b>W. O. McLane,</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9-26-59</b>	
22c. NAME OF CEMETERY OR CREMATORY <b>F'bg. Memorial Park</b>		22d. LOCATION (City, town, or county) (State) <b>Frostburg, Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Joseph R. Durst, Frostburg, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 28 59</b>	
24b. REGISTRAR'S SIGNATURE <b>Arthur R. Kraus</b>		DATE	

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

<p>NAME: <u>John</u></p>		<p>RESIDENCE: <u>123 Main St.</u></p>	
<p>AGE: <u>45</u></p>		<p>SEX: <u>Male</u></p>	
<p>DATE OF BIRTH: <u>1910</u></p>		<p>DATE OF DEATH: <u>1950</u></p>	
<p>CAUSE OF DEATH: <u>Heart Disease</u></p>		<p>MANNER OF DEATH: <u>Natural</u></p>	
<p>PLACE OF DEATH: <u>Home</u></p>		<p>ATTENDING PHYSICIAN: <u>Dr. Smith</u></p>	
<p>REPORTED BY: <u>John Doe</u></p>		<p>DATE OF REPORT: <u>1950</u></p>	
<p>SIGNATURE OF EXAMINER: <u>[Signature]</u></p>		<p>DATE OF EXAMINATION: <u>1950</u></p>	

09794

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>ALLEGANY</b> <b>MARYLAND</b>			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <b>MARYLAND</b> b. COUNTY <b>ALLEGANY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>CUMBERLAND</b>		c. LENGTH OF STAY IN 1b <b>18 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>LONA CONING, MARYLAND</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>MEMORIAL HOSPITAL</b>			d. STREET ADDRESS <b>CHARLESTON STREET</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>HOWARD</b> Middle <b>THOMAS</b> Last <b>WILSON</b>			4. DATE OF DEATH Month <b>SEPTEMBER</b> Day <b>9</b> Year <b>19 59</b>		
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>19th. NOVEMBER 27*1896 62 62 yrs.</b>		9. AGE (In years last birthday) <b>62 62 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
13. FATHER'S NAME <b>William WILSON</b>			14. MOTHER'S MAIDEN NAME <b>REBECCA METZ</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>INFORMANT WARWICK &amp; MEMORIAL AVENUE MEMORIAL HOSPITAL - CUMBERLAND, MD.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Squamous Cell Carcinoma of</b> 141.9 DUE TO <b>Tongue &amp; widespread metastases Nov '57</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I attended the deceased from <b>8. 22. 19 59</b> to <b>9. 9. 19 59</b> that I last saw the deceased alive on <b>9. 9. 19 59</b> , and that death occurred at <b>4:40 P.</b> from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>W.F. Williams</b>			ADDRESS (Street, city or town, state) <b>MD. Cumberland Md 91059</b>		
PHYSICIAN'S NAME (Type) <b>DR. W.F. WILLIAMS</b>			DATE SIGNED		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>9/12/1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Oak Hill Cemetery</b>	
				22d. LOCATION (City, town, or county) (State) <b>Lonaconing, MD.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>GEORGE EICHHORN</b>			ADDRESS <b>LONA CONING, MD.</b>		24a. REC'D BY REGISTRAR <b>SEP 14 '59</b>
					24b. REGISTRAR'S SIGNATURE <b>Arthur S. Frank</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4

may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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CERTIFICATE OF DEATH

0873

DATE OF DEATH

DECEASED

PLACE OF DEATH

DATE OF BIRTH

AGE

SEX

PLACE OF BIRTH

EDUCATION

DATE

PLACE

TIME

CAUSE

MANNER

REPORTED BY

DATE OF DEATH

PLACE OF DEATH

DATE

PLACE

SEX

DATE OF BIRTH

AGE

PLACE OF BIRTH

EDUCATION

DATE OF DEATH

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DATE OF DEATH

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained in your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AT5ME  
SM 2/57

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

09795

09788

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Allegany</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Allegany</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cumberland</b>		c. LENGTH OF STAY IN TB		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>02 Cumberland</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>B&amp;O Railroad Yards, Cumberland Md.</b>				d. STREET ADDRESS <b>Box 80 Potomac Park</b>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Vermont Gilbert Zollner</b>			4. DATE OF DEATH Month Day Year <b>Sept. 3 1959</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 7, 1923</b>		9. AGE (In years last birthday) <b>36</b> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carman Helper</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Railroad</b>		11. BIRTHPLACE (State or foreign country) <b>Cumberland, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>Oswald G. Zollner</b>		
14. MOTHER'S MAIDEN NAME <b>Clara E. Kaylor</b>			15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service] <b>yes War II</b>		
16. SOCIAL SECURITY NO.			17. INFORMANT Address <b>Grant E. Zollner, Cumberland, Md.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gun Shot Wound Head</b> <b>976x</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Self inflicted</b> (c) <b>Mentally ill -</b> DUE TO PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>-</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Gun shot wound head self inflicted</b>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>9/3/59</b>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Don't know</b>	
20f. (City or town) (County) (State) <b>Cum. Alleg. Md.</b>					
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> . and in my opinion death resulted from: Natural causes <input type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input checked="" type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>Dr. Richard J. Williams</b>		EXAMINER'S NAME (Type) <b>Dr. Richard J. Williams</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> (acting)	
DATE SIGNED <b>9/3/59</b>					
22a. BURIAL, CREMATION, REMOVAL (specify) <b>Burial</b>		22b. DATE THEREOF <b>9-5-1959</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Davis Memorial Cemetery</b>	
22d. LOCATION (City, town, or county) (State) <b>Cumberland, Md.</b>		23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <b>James F. Scarpelli, Cumberland, Md.</b>		24a. REC'D BY REGISTRAR <b>SEP 8 '59</b>	
24b. REGISTRAR'S SIGNATURE <b>C. L. H. H. H.</b>					

1. Name of patient  
2. Age  
3. Sex  
4. Race  
5. Date of birth  
6. Date of death  
7. Cause of death  
8. Place of death  
9. Name of physician  
10. Name of attending nurse  
11. Name of hospital  
12. Name of city  
13. Name of county  
14. Name of state

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MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. Name of patient  
2. Age  
3. Sex  
4. Race  
5. Date of birth  
6. Date of death  
7. Cause of death  
8. Place of death  
9. Name of physician  
10. Name of attending nurse  
11. Name of hospital  
12. Name of city  
13. Name of county  
14. Name of state